

102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena P.O. Sillery Bay</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>				d. STREET ADDRESS <u>Rt 1 - Box 250</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ABEL</u> Last <u>ABEL</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>			
11. BIRTH PLACE (State or foreign country) <u>York, Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frederick Abel</u>				14. MOTHER'S MAIDEN NAME <u>Emma Heidler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-10-0241</u>			
17. INFORMANT <u>Mrs Nellie E. Abel</u>				Address <u>Same As Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, terminal</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiectasis, with pulmonary emphysema</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>one year</u> <u>Two years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 1957</u> , to <u>Jan 31 1959</u> , that I last saw the deceased alive on <u>Jan 30 1959</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Mountain Road</u>				DATE SIGNED <u>1/31/59</u>			
ACTUAL SIGNATURE <u>Arthur Lanford Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ARTHUR LANFORD JR MD.</u>				<u>Pasadena P.O. Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Feb. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home Glen Burnie Md.</u>				24a. REC'D BY REGISTRAR <u>DATE B 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

05

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PLACE OF DEATH</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. CAUSE OF DEATH</p> <p>15. MANNER OF DEATH</p> <p>16. SIGNATURE OF PHYSICIAN</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF NEXT OF KIN</p> <p>21. SIGNATURE OF CLERGYMAN</p> <p>22. SIGNATURE OF JUDGE</p> <p>23. SIGNATURE OF SHERIFF</p> <p>24. SIGNATURE OF CORONER</p> <p>25. SIGNATURE OF JURY</p> <p>26. SIGNATURE OF COURT</p> <p>27. SIGNATURE OF STATE</p> <p>28. SIGNATURE OF UNION</p> <p>29. SIGNATURE OF COUNTY</p> <p>30. SIGNATURE OF CITY</p> <p>31. SIGNATURE OF TOWNSHIP</p> <p>32. SIGNATURE OF WARD</p> <p>33. SIGNATURE OF BLOCK</p> <p>34. SIGNATURE OF STREET</p> <p>35. SIGNATURE OF ALLEY</p> <p>36. SIGNATURE OF LOT</p> <p>37. SIGNATURE OF TRACT</p> <p>38. SIGNATURE OF PARCEL</p> <p>39. SIGNATURE OF DISTRICT</p> <p>40. SIGNATURE OF PRECINCT</p> <p>41. SIGNATURE OF CONGRESSIONAL DISTRICT</p> <p>42. SIGNATURE OF LEGISLATIVE DISTRICT</p> <p>43. SIGNATURE OF JUDICIAL DISTRICT</p> <p>44. SIGNATURE OF COUNTY DISTRICT</p> <p>45. SIGNATURE OF CITY DISTRICT</p> <p>46. SIGNATURE OF TOWNSHIP DISTRICT</p> <p>47. SIGNATURE OF WARD DISTRICT</p> <p>48. SIGNATURE OF BLOCK DISTRICT</p> <p>49. SIGNATURE OF STREET DISTRICT</p> <p>50. SIGNATURE OF ALLEY DISTRICT</p> <p>51. SIGNATURE OF LOT DISTRICT</p> <p>52. SIGNATURE OF TRACT DISTRICT</p> <p>53. SIGNATURE OF PARCEL DISTRICT</p> <p>54. SIGNATURE OF DISTRICT DISTRICT</p> <p>55. SIGNATURE OF PRECINCT DISTRICT</p> <p>56. SIGNATURE OF CONGRESSIONAL DISTRICT DISTRICT</p> <p>57. SIGNATURE OF LEGISLATIVE DISTRICT DISTRICT</p> <p>58. SIGNATURE OF JUDICIAL DISTRICT DISTRICT</p> <p>59. SIGNATURE OF COUNTY DISTRICT DISTRICT</p> <p>60. SIGNATURE OF CITY DISTRICT DISTRICT</p> <p>61. SIGNATURE OF TOWNSHIP DISTRICT DISTRICT</p> <p>62. SIGNATURE OF WARD DISTRICT DISTRICT</p> <p>63. SIGNATURE OF BLOCK DISTRICT DISTRICT</p> <p>64. SIGNATURE OF STREET DISTRICT DISTRICT</p> <p>65. SIGNATURE OF ALLEY DISTRICT DISTRICT</p> <p>66. SIGNATURE OF LOT DISTRICT DISTRICT</p> <p>67. SIGNATURE OF TRACT DISTRICT DISTRICT</p> <p>68. SIGNATURE OF PARCEL DISTRICT DISTRICT</p> <p>69. SIGNATURE OF DISTRICT DISTRICT DISTRICT</p> <p>70. SIGNATURE OF PRECINCT DISTRICT DISTRICT</p> <p>71. SIGNATURE OF CONGRESSIONAL DISTRICT DISTRICT DISTRICT</p> <p>72. SIGNATURE OF LEGISLATIVE DISTRICT DISTRICT DISTRICT</p> <p>73. SIGNATURE OF JUDICIAL DISTRICT DISTRICT DISTRICT</p> <p>74. SIGNATURE OF COUNTY DISTRICT DISTRICT DISTRICT</p> <p>75. SIGNATURE OF CITY DISTRICT DISTRICT DISTRICT</p> <p>76. SIGNATURE OF TOWNSHIP DISTRICT DISTRICT DISTRICT</p> <p>77. SIGNATURE OF WARD DISTRICT DISTRICT DISTRICT</p> <p>78. SIGNATURE OF BLOCK DISTRICT DISTRICT DISTRICT</p> <p>79. SIGNATURE OF STREET DISTRICT DISTRICT DISTRICT</p> <p>80. SIGNATURE OF ALLEY DISTRICT DISTRICT DISTRICT</p> <p>81. SIGNATURE OF LOT DISTRICT DISTRICT DISTRICT</p> <p>82. SIGNATURE OF TRACT DISTRICT DISTRICT DISTRICT</p> <p>83. SIGNATURE OF PARCEL DISTRICT DISTRICT DISTRICT</p> <p>84. SIGNATURE OF DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>85. SIGNATURE OF PRECINCT DISTRICT DISTRICT DISTRICT</p> <p>86. SIGNATURE OF CONGRESSIONAL DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>87. SIGNATURE OF LEGISLATIVE DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>88. SIGNATURE OF JUDICIAL DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>89. SIGNATURE OF COUNTY DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>90. SIGNATURE OF CITY DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>91. SIGNATURE OF TOWNSHIP DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>92. SIGNATURE OF WARD DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>93. SIGNATURE OF BLOCK DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>94. SIGNATURE OF STREET DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>95. SIGNATURE OF ALLEY DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>96. SIGNATURE OF LOT DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>97. SIGNATURE OF TRACT DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>98. SIGNATURE OF PARCEL DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>99. SIGNATURE OF DISTRICT DISTRICT DISTRICT DISTRICT DISTRICT</p> <p>100. SIGNATURE OF PRECINCT DISTRICT DISTRICT DISTRICT DISTRICT DISTRICT</p>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>237 HANOVER ST.</u>				d. STREET ADDRESS <u>237 HANOVER</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Richard</u> Last <u>ADAMS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine-Operator - Civil Ser.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Adams</u>				14. MOTHER'S MAIDEN NAME <u>Kate Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Aurilia I. Adams - 237 Hanover</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urasmia acuta</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Broncho Pneumonia</u> DUE TO (c) <u>Virus type Influenzae</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 17</u> , 19 <u>59</u> , to <u>Jan 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-29</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Oliver Purvis</u>				ADDRESS (Street, city or town, state) <u>40 Franklin St, Annapolis Md.</u> DATE SIGNED <u>1-31-59</u>			
PHYSICIAN'S NAME (Type) <u>J. OLIVER PURVIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>ANNA, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

STATE DEPARTMENT OF HEALTH - BALTIMORE 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b 15 years			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 6 Barnes Lane, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Gene Ballard Austin			4. DATE OF DEATH Month Day Year January 18 19 59		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 17, 1938		9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Clifton Austin		14. MOTHER'S MAIDEN NAME Virginia Estelle Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Social Service, Children's Center District Training School Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cystic disease of the lungs 759.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) --- INTERVAL BETWEEN ONSET AND DEATH one year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mental retardation 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Hour a. m. p. m. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---		20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from 3/26/43 , 19 --- , to 1/18/59 , 19 --- , that I last saw the deceased alive on 1/18/59 , 19 --- , and that death occurred at 1:25 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Margaret W. Mola		ADDRESS (Street, city or town, state) District Training School Children's Center, Laurel, Md.		DATE SIGNED 1/19/59	
PHYSICIAN'S NAME (Type) Margaret W. Mola, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Reburied		22b. DATE THEREOF Jan. 21, 1959		22c. NAME OF CEMETERY OR CREMATORY District Training School	
22d. LOCATION (City, town, or county) Laurel, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE John J. Howell Jr.		24a. REC'D BY REGISTRAR DATE JAN 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank					

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF BIRTH _____		PLACE OF BIRTH _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal		MEDICAL HISTORY _____	
OCCUPATION _____		EDUCATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		RELIGION _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____	
SIGNATURE OF JURY _____		SIGNATURE OF JUDGE _____	
SIGNATURE OF CLERK _____		SIGNATURE OF REGISTRAR _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>421 Maple Lane N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL MAGGIO AVARA</u>				4. DATE OF DEATH Month Day Year <u>JAN. 13 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 January 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce hauling</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes - USA</u>	
13. FATHER'S NAME <u>Gregory Avara (dec.)</u>				14. MOTHER'S MAIDEN NAME <u>Grace Maggio (dec.)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No -</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-30-3670</u>		17. INFORMANT Address <u>Mrs. Helen M. Avara 421 Maple Lane NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>auricular fibrillation</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, jaundice, anasarca</u> DUE TO (c) <u>chronic glomerulonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yrs.</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arthritis, hiatus hernia.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>28 June</u> , 19 <u>58</u> , to <u>13 Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 January</u> , 19 <u>59</u> , and that death occurred at <u>9⁰⁰ P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.F. Manuzak</u>				ADDRESS (Street, city or town, state) <u>901 EDGERLY RD.</u> DATE SIGNED <u>13 Jan 1959</u>			
PHYSICIAN'S NAME (Type) <u>H.F. MANUZAK</u>				GLEN BURNIE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>1/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Pt Charles, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. F. Manuzak</u> ADDRESS <u>901 Edgerly Rd.</u>				24a. REC'D BY REGISTRAR <u>JAN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Knecht</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JOHN DOE		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 12/15/1925		5. PLACE OF BIRTH BALTIMORE, MD		6. RACE WHITE		7. OCCUPATION CLERK		8. MARITAL STATUS MARRIED		9. DATE OF DEATH 10/10/1970		10. PLACE OF DEATH HOSPITAL		11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF DECEASED [Signature]		15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF CLERK [Signature]		18. SIGNATURE OF NURSE [Signature]		19. SIGNATURE OF CHURCH CLERK [Signature]		20. SIGNATURE OF OTHER [Signature]	
21. FULL ADDRESS 123 MAIN ST, BALTIMORE, MD 21201		22. CITY BALTIMORE		23. STATE MD		24. ZIP CODE 21201		25. COUNTY BALTIMORE		26. DISTRICT 1		27. WARD 1		28. BLOCK 1		29. LOT 1		30. UNIT 1		31. ZONE 1		32. TRACT 1		33. SUBTRACT 1		34. PARCEL 1		35. LOT 1		36. UNIT 1		37. ZONE 1		38. TRACT 1		39. SUBTRACT 1		40. PARCEL 1	
41. FULL ADDRESS 123 MAIN ST, BALTIMORE, MD 21201		42. CITY BALTIMORE		43. STATE MD		44. ZIP CODE 21201		45. COUNTY BALTIMORE		46. DISTRICT 1		47. WARD 1		48. BLOCK 1		49. LOT 1		50. UNIT 1		51. ZONE 1		52. TRACT 1		53. SUBTRACT 1		54. PARCEL 1		55. LOT 1		56. UNIT 1		57. ZONE 1		58. TRACT 1		59. SUBTRACT 1		60. PARCEL 1	
61. FULL ADDRESS 123 MAIN ST, BALTIMORE, MD 21201		62. CITY BALTIMORE		63. STATE MD		64. ZIP CODE 21201		65. COUNTY BALTIMORE		66. DISTRICT 1		67. WARD 1		68. BLOCK 1		69. LOT 1		70. UNIT 1		71. ZONE 1		72. TRACT 1		73. SUBTRACT 1		74. PARCEL 1		75. LOT 1		76. UNIT 1		77. ZONE 1		78. TRACT 1		79. SUBTRACT 1		80. PARCEL 1	
81. FULL ADDRESS 123 MAIN ST, BALTIMORE, MD 21201		82. CITY BALTIMORE		83. STATE MD		84. ZIP CODE 21201		85. COUNTY BALTIMORE		86. DISTRICT 1		87. WARD 1		88. BLOCK 1		89. LOT 1		90. UNIT 1		91. ZONE 1		92. TRACT 1		93. SUBTRACT 1		94. PARCEL 1		95. LOT 1		96. UNIT 1		97. ZONE 1		98. TRACT 1		99. SUBTRACT 1		100. PARCEL 1	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY OF BALTIMORE, MD, AND TO THE CLERK OF THE COURT OF COMMON PLEAS, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

138

CERTIFICATE OF DEATH

00105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1m 20a		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton d. STREET ADDRESS P. O. Box 192 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ferdinand Phendientar Bacon		4. DATE OF DEATH Month 1 Day 29 Year 1959				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/82	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Bacon			14. MOTHER'S MAIDEN NAME Laura			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7/5x IMMEDIATE CAUSE (a) Septicopyemia DUE TO Decubital Ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 023x Syphilitic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----				
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/9 , 19 58 to 1/29 , 19 59 , that I last saw the deceased alive on 1/29 , 19 59 , and that death occurred at 8:15A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital, Md. 1/29/59 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 1/29/59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/59		22c. NAME OF CEMETERY OR CREMATORY Cecilton		22d. LOCATION (City, town, or county) (State) Cecilton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward F. Williams ADDRESS Millington, Md.			24a. REC'D BY REGISTRAR FEB 4 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kious	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1918

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1873</u></p>	
<p>5. Place of birth: <u>England</u></p>		<p>6. Usual residence: <u>123 Main St, Baltimore, Md.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Date of death: <u>Dec 10, 1918</u></p>	
<p>9. Time of death: <u>10:30 AM</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Signature of registrar: <u>John Doe</u></p>	
<p>13. Signature of informant: <u>John Doe</u></p>		<p>14. Signature of witness: <u>John Doe</u></p>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Army Hospital				d. STREET ADDRESS 204 6th St			
3. NAME OF DECEASED (Type or print) First Betty Middle Ann Last Bailey				4. DATE OF DEATH Month January Day 2 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 January 1959	
9. AGE (In years lost birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Farmer Bailey		14. MOTHER'S MAIDEN NAME Margaret Burns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Father: Address Farmer Bailey, 204 6th St, Laurel, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 Jan 1959 , to 2 Jan 1959 , that I last saw the deceased alive on 2 Jan 1959 , and that death occurred at 0400 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sol Colsky				ADDRESS (Street, city or town, state) U.S. Army Hospital, Ft Meade, Md			
DATE SIGNED 2 Jan 1959				DATE SIGNED			
PHYSICIAN'S NAME (Type) SOL COLSKY, CAPT, MC				U. S. ARMY HOSP, FT GEO G MEADE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5 Jan 58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore		22d. LOCATION (City, town, or county) (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE WM COOK, INC, BALTIMORE, Md, Maryland				24a. REC'D BY REGISTRAR DATE JAN 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 84 West Washington St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Alfred Last BLACKSTONE				4. DATE OF DEATH Month JAN Day 22 Year 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-79		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Buck BLACKSTONE				14. MOTHER'S MAIDEN NAME Elizabeth CARPENTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT U.S. Naval Hospital Annapolis, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis 610x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign prostatic hyperphasia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 Jan , 19 59 , to 22 Jan , 19 59 , that I last saw the deceased alive on 22 Jan , 19 59 , and that death occurred at 5:08P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 23 Jan 1959							
ACTUAL SIGNATURE R. I. HOCHMAN M.D.				DATE SIGNED 23 Jan 1959			
PHYSICIAN'S NAME (Type) R. I. HOCHMAN LT MC USN				U.S. Naval Hospital, Anna. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1-26-59		Brewer Hall		Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reesett				ADDRESS 108 Wash St. Annapolis		24a. REC'D BY REGISTRAR DATE JAN 26 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00108

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

140

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Quaterfield Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilhelm Carl August Blandow</u>				4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/87</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Maintenance man.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Germany, Europe.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Adolph Blandow</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Rienow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-4172 A</u>		17. INFORMANT Address <u>421 Mercer Ave.</u> <u>Mr and Mrs. Karl Pfeil, River Edge, N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to smoke.</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Defective stove caused excess of smoke in the room.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>Unknown</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Severn A.A.Md.</u>	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/8/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>Jan 10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Ketchikan Hyndley Brooklyn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard C. Smith</u>				ADDRESS <u>Blenn / Baltimore Md</u>		24a. REC'D BY REGISTRAR <u>JAN 12 59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

DATE OF DEATH

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CERTIFICATE OF DEATH

00109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 18y 15d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 620 N. Caroline Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clyde Middle Last Brown		4. DATE OF DEATH Month 1 Day 18 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1904
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Clark		14. MOTHER'S MAIDEN NAME Ethel Jordan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Hemorrhage DUE TO Arteriosclerotic Cardiovascular Disease with Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 2:00 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/3/ 19 40 , to 1/18 19 59 , that I last saw the deceased alive on 1/18 19 59 and that death occurred at 10:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		DATE SIGNED 1/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-59	22c. NAME OF CEMETERY OR CREMATORY Beth. National Cem	22d. LOCATION (City, town, or county) (State) Beth. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Holstead</i>		ADDRESS 918 Druid Hill Ave.	
24a. REC'D BY REGISTRAR DATE JAN 22 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

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1

2

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00110

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sherwood Forest		d. STREET ADDRESS Crownsville Baltimore 3V01-4 1538 McCulloh Street Crownsville State Hospital	
3. NAME OF DECEASED (Type or print) PAUL		4. DATE OF DEATH (FOUND) Jan. 14 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1918
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Singer		10b. KIND OF BUSINESS OR INDUSTRY Show business	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Brown		14. MOTHER'S MAIDEN NAME Martha Queen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Martha Clark 3406 Duvall Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposure to cold	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Unknown	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cove - Woods	20f. (City or town) (County) (State) - Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		DATE SIGNED 1/15/59	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 19, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Gibson		24a. REC'D BY REGISTRAR JAN 19 59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G237 1-14-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>La.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel - P.O.</u> c. LENGTH OF STAY IN lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beacon "In bed at home"</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurelville</u> d. STREET ADDRESS <u>138-2</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel Marie Bruce</u> First Middle Last 4. DATE OF DEATH <u>January 8</u> Month Day Year 5. SEX <u>F.</u> 6. COLOR OR RACE <u>C.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/16/98</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Laurel, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Eager</u> 14. MOTHER'S MAIDEN NAME <u>Bessie Matthews</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Fauder</u> EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUDER, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/8/59</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Laurel, Md.</u>		22b. DATE THEREOF <u>1/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bacon Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 12 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pines on Severn Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pines on the Severn Arundel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annette Elisabeth Buxton</u>		4. DATE OF DEATH Jan. 28 1959	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Healey Buxton</u>	
14. MOTHER'S MAIDEN NAME <u>Gene Curtis (CURTIS)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>MABELYN B. Rucker</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>Jan 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 28</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>1-28-59</u> ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville - Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>STEWART & MOWEN Co - 108 W. North Av. - Balt</u>		24a. REC'D BY REGISTRAR <u>JAN 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Clifford E. Hays</u>

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VS A15 (4)
15M 10/57

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Waterloo</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Arthur</i> Middle <i>Campbell, Jr.</i> Last <i>Campbell, Jr.</i>		4. DATE OF DEATH Month <i>1</i> - Day <i>31</i> - Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1882</i> <i>7-24-1882</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min.	IF UNDER 24 HRS. Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Blacksmith</i>	
11. BIRTHPLACE (State or foreign country) <i>Howard county, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arthur Campbell, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Marie Johns</i>		Address <i>Edgewater, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive heart disease</i> (c) <i>Hypertensive cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 weeks</i> <i>unknown duration</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a. 11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-31-</i> , 19 <i>59</i> , to <i>1-31-</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1-31-</i> , 19 <i>59</i> , and that death occurred at <i>11:55</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>		ADDRESS (Street, city or town, state) <i>Rt 1 Box 277-M</i>	
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim, M.D.</i>		DATE SIGNED <i>2-1-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2-4-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>FREEDOM</i>		22d. LOCATION (City, town, or county) (State) <i>JAYESVILLE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. HIGGINBOTHAM</i>		ADDRESS <i>ELLICOTT CITY MD</i>	
24a. REC'D BY REGISTRAR <i>FEB 4 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

CERTIFICATE OF DEATH

Reg. Dist. No. 127

146

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>12005</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 03X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				d. STREET ADDRESS <u>2804 Alden Rd, Baltimore</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Alan</u> Middle <u>Bryson</u> Last <u>Carner jr</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 January 59</u>		9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>37</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Alan B Carner</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann Jung</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father:</u> Address <u>Alan B Carner 2804 Alden Rd Baltimore Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. n.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>2 Jan</u> , 19 <u>59</u> , to <u>3 January</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 January</u> , 19 <u>59</u> , and that death occurred at <u>0915 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>3 Jan 59</u>							
ACTUAL SIGNATURE <u>Frank L. Gruskay</u> M.D. <u>U.S. Army Hospital, Ft Meade, Md</u>							
PHYSICIAN'S NAME (Type) <u>FRANK L. GRUSKAY, Capt., MC</u> <u>U.S. Army Hospital, Ft Meade, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William Cook, Inc.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 16y 8m 19d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 910 North Wolfe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel		4. DATE OF DEATH Month 1 Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Samuel Carter		14. MOTHER'S MAIDEN NAME Lucie Pollard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from 5/7 , 19 42 , to 1/25/ , 19 59 , that I last saw the deceased alive on 1/25/ , 19 59 , and that death occurred at 3:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Reissman		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/26/59	
PHYSICIAN'S NAME (Type) Hildegard Reissman, M. D.		Crownsville State Hospital, Md. 1/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/31/59	22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM.	22d. LOCATION (City, town, or county) (State) A. A. COUNTY MD.
23. FUNERAL DIRECTOR'S SIGNATURE Robt. E. Williams - 1701 N. BOND ST.		24a. REC'D. BY REGISTRAR FEB 4 59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hirsch	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

MARRIAGE

EDUCATION

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

SEX

AGE

RELIGION

EDUCATION

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

RELIGION

EDUCATION

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

RELIGION

EDUCATION

PLACE OF BIRTH

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DATE OF BIRTH

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AGE

RELIGION

EDUCATION

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

RELIGION

EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

148

CERTIFICATE OF DEATH

00116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A A County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANNS Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A A County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x millersville Md.</u> d. STREET ADDRESS <u>CECIL Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>T</u> Middle <u>childs</u> Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/13/1878</u> 9. AGE (In years lost birthday) <u>80</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>JANUARY 23</u> 19 <u>59</u> Month <u>JANUARY</u> Day <u>23</u> Year <u>1959</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <u>Nathan Soppe Childs</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Turnbull</u> INFORMANT <u>Jean Williams</u> Address <u>Millersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Fracture Right Hip.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u> <u>2 1/2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>Jan 22-59</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>16</u> 20f. City or town (County) (State) <u>16</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>Jan 22-59</u> to <u>Jan 23-59</u> , that I last saw the deceased alive on <u>Jan 22-59</u> and that death occurred at <u>6:55 PM</u> with the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1-24-59</u> DATE SIGNED <u>1-24-59</u>		22. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR. JOSEPH LIPSKEY</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE OF REMOVAL <u>1-26-59</u> 23c. ADDRESS <u>HOPPING FUNERAL HOME, Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jan 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

00116

STATE OF NEW YORK

1887

IN SENATE,
January 10, 1887.
REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE,
IN ANSWER TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1886.
ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1887.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1887.

DR. JOSEPH LIPKOV

1-2-10

10

149
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>A.A. Co</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN Pk.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 W. 11th Ave.</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William E. Chory Sr.</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 1, 1895</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD. DRYDOCK</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL CHORY</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>231-09-2896</u>		17. INFORMANT <u>FAMILY</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 10, 1959</u> , to <u>Jan 9, 1959</u> , that I last saw the deceased alive on <u>Jan 8, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Keister, M.D.</u>		ADDRESS (Street, city or town, state) <u>302 Patapsco Ave</u>		DATE SIGNED <u>1/9/59</u>			
PHYSICIAN'S NAME (Type) <u>302 Patapsco KEISTER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>B</u>	<u>1-13-59</u>	<u>CEPAR HILL CEM.</u>		<u>BALTIMORE MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>		ADDRESS <u>130 E. Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00118

105

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL HOSPT</u>		d. STREET ADDRESS <u>925 BOUCHER AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>M.</u> Last <u>CHRISTENSON</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOAT BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIP YARD</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES H. CHRISTENSON</u>		14. MOTHER'S MAIDEN NAME <u>SADIE E. DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SADIE E. CHRISTENSON</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10, 1959</u> to <u>Jan 19, 1959</u> , that I last saw the deceased alive on <u>1-19-59</u> , and that death occurred on <u>1-19-59</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>JAMES R. MARTIN</u>		DATE SIGNED <u>1-20-59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		ADDRESS <u>65 SHAW ST ANNAPOLIS, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-21-59</u>	22b. DATE THEREOF <u>1-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son Annapolis MD</u>		24a. REC'D BY REGISTRAR <u>JAN 21 '59</u>	
ADDRESS <u>Annapolis MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

150

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b 3 Yrs 01 Mo 4 Ds	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 2930 E. Fayette Street	
3. NAME OF DECEASED (Type or print) First David Middle Joshua Last Creamer		4. DATE OF DEATH Month January Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1889
9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY L. Mayers & Son	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank L. Creamer		14. MOTHER'S MAIDEN NAME Catherine Koehler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-7599	
17. INFORMANT Helen Oelmann Creamer, wife, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 443X DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 1/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/26/59	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR 26 59	
ADDRESS Funeral Home 3331 Brehms Lane		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Wilson</u> Middle <u>Cullen</u> Last		4. DATE OF DEATH <u>Jan.</u> Month <u>1</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>David Cullen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Meritt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-2693</u>	
17. INFORMANT <u>Wife, Nan Cullen</u> Address <u>Box 137 Mayo, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X Congestive heart failure and respiratory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> (c) <u>and carcinoma of right lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 Month</u> <u>6 Month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 25, 1958</u> , to <u>Dec 31, 1958</u> , that I last saw the deceased alive on <u>Jan. 1, 1959</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sylvia M. Lin</u> M.D.		ADDRESS (Street, city or town, state) <u>RFD #1 Box 277M Edgewater, Md.</u>	
DATE SIGNED <u>1-1-59</u>			
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Fall Church, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoppe</u> ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 6 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00121

106

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>aa.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Allen Pinkney Dawson</i>		4. DATE OF DEATH <i>1 - 11 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-17-1878</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR: Months <i>1</i> Days <i>11</i> Hours <i>19</i> Min. <i>59</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Warman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crab-Oysters</i>	
11. BIRTHPLACE (State or foreign country) <i>Mayo Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph J. Dawson</i>		14. MOTHER'S MAIDEN NAME <i>Anna M. Dawson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Lola J. Dawson</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Auricular fibrillation</i> DUE TO (c) <i>Anticoagulant c.v.d.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-10-1959</i> , to <i>1-11-1959</i> , that I last saw the deceased alive on <i>1-11-1959</i> , and that death occurred at <i>8:32 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		M.D. <i>12116th St. 1-11-59</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) <i>Annapolis Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-13-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial Cent</i>		22d. LOCATION (City, town, or county) <i>Mayo</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Dwyer</i>		24a. REC'D BY REGISTRAR <i>JAN 14 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>William L. Jones</i>			

CERTIFICATE OF DEATH

06

1. PLACE OF DEATH

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF TOWNSHIP CLERK

16. SIGNATURE OF COUNTY CLERK

17. SIGNATURE OF STATE CLERK

18. SIGNATURE OF FEDERAL CLERK

19. SIGNATURE OF POSTAL CLERK

20. SIGNATURE OF OTHER CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital		/d. STREET ADDRESS Box 51	
3. NAME OF DECEASED (Type or print) First Middle Last Dennis		4. DATE OF DEATH Month Day Year January 24 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1959
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 1 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lorenzo Thomas Dennis		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mother		Address (same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 24, 19 59 , to January 24, 19 59 , that I last saw the deceased alive on January 24, 19 59 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Michael Monias M.D. 69 Franklin Street, Annapolis, Md. 1/24			
ACTUAL SIGNATURE Michael Monias			
PHYSICIAN'S NAME (Type) Dr. Michael Monias (Same)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-26-59	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Annapolis - Md.	
24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kiana	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

CERTIFICATE OF DEATH

103

Date of Birth

Date of Death

HUSBAND

WIFE

CHILD OF DEATH

CHILD OF DEATH

CHILD OF DEATH

CHILD OF DEATH

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

152

tems 7,10,11,12,13,14, Film G238 2-18-59 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Columbia Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Columbia Beach</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HUBERT</u> Last <u>DIX</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spotter</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Greensboro, N. C.</u>
13. FATHER'S NAME <u>Rufus Dix</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mary Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jarvis, 1432 You St., N. W., Wash. 9, D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF BIRTH: _____
PLACE OF BIRTH: _____
OCCUPATION: _____
EDUCATION: _____
MARRIAGE: _____
RELIGION: _____
RACE: _____
COLOR: _____
SEX: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF EXAMINER: _____
TITLE OF EXAMINER: _____
DATE OF EXAMINATION: _____

1. CAUSE OF DEATH: _____
2. CLINICAL HISTORY: _____
3. PHYSICAL EXAMINATION: _____
4. LABORATORY EXAMINATIONS: _____
5. OTHER INFORMATION: _____
6. SIGNATURE OF EXAMINER: _____
7. TITLE OF EXAMINER: _____
8. DATE OF EXAMINATION: _____
9. PLACE OF EXAMINATION: _____
10. NAME OF DECEASED: _____
11. AGE: _____
12. SEX: _____
13. DATE OF BIRTH: _____
14. PLACE OF BIRTH: _____
15. OCCUPATION: _____
16. EDUCATION: _____
17. MARRIAGE: _____
18. RELIGION: _____
19. RACE: _____
20. COLOR: _____
21. SEX: _____
22. DATE OF DEATH: _____
23. PLACE OF DEATH: _____
24. CAUSE OF DEATH: _____
25. MANNER OF DEATH: _____
26. SIGNATURE OF EXAMINER: _____
27. TITLE OF EXAMINER: _____
28. DATE OF EXAMINATION: _____

153 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				d. STREET ADDRESS <u>4203 Marbain Court</u>			
3. NAME OF DECEASED (Type or print) First <u>BRUCE</u> Middle Last <u>DOTSON</u>				4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 January 1920</u>		9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Dotson</u>				14. MOTHER'S MAIDEN NAME <u>Ida Fleming</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>226-18-5357</u>		17. INFORMANT <u>Wife</u> Address <u>Ina T. Dotson, 4203 Marbain Court, Balto Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Glomerulonephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>0500 17 Jan 19 59</u> to <u>0525 17 Jan 19 59</u> that I last saw the deceased alive on <u>17 Jan 1959</u> , and that death occurred at <u>0515A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul M. Jackson</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. ARMY HOSP, FT MEADE, MD 17 Jan 59</u>			
PHYSICIAN'S NAME (Type) <u>PAUL M. JACKSON, CAPT, MC</u>				U. S. ARMY HOSP, FT MEADE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>20 Jan 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYLVAN SHORES				c. LENGTH OF STAY IN 1b 9 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD DOVE				4. DATE OF DEATH Month JANUARY Day 23 Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8, 1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PACKER, BUREAU OF PRINTING & ENGRAVING		10b. KIND OF BUSINESS OR INDUSTRY DISTRICT OF COLUMBIA		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME G EORGE WASHINGTON DOVE				14. MOTHER'S MAIDEN NAME ANN ELIZABETH BIXLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES SPANISH-AMERICAN		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address EDNA S. DOVE, SYLVAN SHORES, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIO SCLEROSIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 24 HOURS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from JULY 1955 , to 22 JAN 1959 , that I last saw the deceased alive on 22 JAN 1959 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck				ADDRESS (Street, city or town, state) 41 Southgate Ave Cannapolis, Md		DATE SIGNED 1/24/59	
PHYSICIAN'S NAME (Type) EDWARD S. BECK							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 26, 1959	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska				24a. REC'D BY REGISTRAR JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WARTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

155

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 m. 25d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Henry Dudley		4. DATE OF DEATH Month Day Year 1 17 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Variety		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL RESIDENCE (If outside corporate limits, write RURAL and give nearest town) Baltimore		10b. BIRTHPLACE (State or foreign country) Maryland	
11. CITIZEN OF WHAT COUNTRY? USA		12. FATHER'S NAME unknown	
13. MOTHER'S MAIDEN NAME Armenta Dudley		14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
15. SOCIAL SECURITY NO.		16. INFORMANT Marguerite O. Bawman, 1028 Argyle Ave., Baltimore	
17. ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic infarction in the left ventricular wall	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/22 , 19 58 , to 1/17 , 19 59 , that I last saw the deceased alive on 1/17 , 19 59 , and that death occurred at 2 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) State Hospital, Crownsville, Md. DATE SIGNED 1/17/59			
ACTUAL SIGNATURE George McK. Phillips M.D.		PHYSICIAN'S NAME (Type) George McK. Phillips, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frances A. Hensley		24a. REC'D BY REGISTRAR DATE JAN 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume		25. ADDRESS 578 W. Biddle St.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00137

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Marital Status	
John Doe		12/15/1925		Male		White		Married	
Address		City		County		State		Zip	
123 Main St		Baltimore		Baltimore		Maryland		21201	
Occupation		Cause of Death		Date of Death		Time of Death		Place of Death	
Teacher		Heart Disease		12/20/1995		10:30 AM		Home	
Physician		Hospital		Date of Admission		Date of Discharge		Place of Discharge	
Dr. Smith		St. Mary's		12/18/1995		12/20/1995		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant		Signature of Informant	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Date of Death		Date of Death		Date of Death		Date of Death	
12/21/1995		12/20/1995		12/20/1995		12/20/1995		12/20/1995	

RECEIVED

1-1-96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Item # 3, 8414. See Birth Cert. Balto. City - 2/6/59-MB.

CERTIFICATE OF DEATH

00127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARWOOD ANNAPOLIS				c. LENGTH OF STAY IN 1b 15 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle EASTEP, JR. Last EASTEP, JR.				4. DATE OF DEATH Month JAN Day 12 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 58	9. AGE (In years last birthday) 3 wks	IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH EASTEP, SR.				14. MOTHER'S MAIDEN NAME DIANNE ELBEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address ANNE ARUNDEL GENERAL HOSPITAL RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRCULATORY COLLAPSE (c) MALNUTRITION SECONDARY TO QUESTIONABLE CONGENITAL GASTRO-INTESTINAL DEFECT						INTERVAL BETWEEN ONSET AND DEATH 6 hrs 12 hrs 22 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10 JAN , 19 59 , to 12 JAN , 19 59 , that I last saw the deceased alive on 12 JAN , 19 59 , and that death occurred at 7:02 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) RIVER CLUB ESTATES DATE SIGNED 12 JAN 59							
ACTUAL SIGNATURE James I. Hudson, Jr.		M.D. JAMES I. HUDSON, JR. MD		EDGEMATER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 13 1959		22c. NAME OF CEMETERY OR CREMATORY mt Zion		22d. LOCATION (City, town, or county) (State) Lothian Md. HACO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Isaac Hardisty ADDRESS				24a. REC'D BY REGISTRAR DATE JAN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

00132

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Page 1 of 1

DATE OF DEATH

DECEASED

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

NAME OF ASSISTANT DEPUTY

NAME OF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00128

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>331 1st Street</u>				d. STREET ADDRESS <u>331 1st Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET A FRIEMEL</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 13 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1864</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Keider</u>				14. MOTHER'S MAIDEN NAME <u>Barbara (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Gladys E. Boutwell—Daughter— same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>59</u> , to <u>Jan 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 13</u> , 19 <u>59</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Bornsuck</u> M.D.				ADDRESS (Street, city or town, state) <u>Annapolis, Maryland</u> DATE SIGNED <u>1/14/59</u>			
PHYSICIAN'S NAME (Type) <u>S. Bornsuck</u>				<u>Ann Arundel Co</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

00132

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G238 2-3-59 et

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CERTIFICATE OF DEATH

00129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>7 A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 1 Cumberstone</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE BROWN LARVETT</u>		4. DATE OF DEATH Month Day Year <u>Jun 23 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>AA. Co Md</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Richard Tongue</u>	
14. MOTHER'S MAIDEN NAME <u>Birdie Horried</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ellen Smith 1618 Madison Baltimore Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>252.0</u> DUE TO <u>acute gastric large intestine thyroid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial failure</u> DUE TO (c) <u>gangrene both feet</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 21</u> , 19 <u>59</u> , to <u>Jan 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Lothman, Md.</u> DATE SIGNED <u>1-27-59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 27, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chews</u>	22d. LOCATION (City, town, or county) (State) <u>Owensville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kunk</u>

1927-28

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Bacton</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>2 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>311 - 8th Ave SE.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Garton - (Edna Mae)</i> Middle Last		4. DATE OF DEATH <i>Jan 8 1959</i> Month Day Year	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 28 1902</i> yrs. <i>56</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sales</i>	
11. BIRTHPLACE (State or foreign country) <i>Orange Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>	
13. FATHER'S NAME <i>Chas Cluff</i>		14. MOTHER'S MAIDEN NAME <i>Ida Saunders</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>812-36-5751</i>	
17. INFORMANT <i>Floyd Garton</i> Address <i>Baltimore</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Stomach</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1-2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 4</i> , 19 <i>59</i> , to <i>Jan 8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1/8/59</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i>		ADDRESS (Street, city or town, state) <i>203 W. Maple Rd.</i> DATE SIGNED <i>1/8/59</i>	
PHYSICIAN'S NAME (Type) <i>Linthicum Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. ...</i> ADDRESS <i>...</i>		24a. REC'D BY REGISTRAR <i>...</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>GELHAUS</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 15, 1959</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Frederick Elmer Gelhaus</u>			
14. MOTHER'S MAIDEN NAME <u>Agnes Gustofson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. -----				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine Proxia</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature Labor</u> (c) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>1 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>59</u> , to <u>1-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>59</u> , and that death occurred at <u>2:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Shaw Street Annapolis, Maryland</u> <u>January 15, 1959</u>							
ACTUAL SIGNATURE <u>James S. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>James S. Martin MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>				22e. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Carol A. [illegible]</u>				24c. REGISTRAR'S SIGNATURE <u>Carol A. [illegible]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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0018

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>	
<p>4. DATE OF BIRTH [Handwritten: 10/15/1920]</p>		<p>5. PLACE OF BIRTH [Handwritten: New York, N.Y.]</p>		<p>6. OCCUPATION [Handwritten: Teacher]</p>	
<p>7. DATE OF DEATH [Handwritten: 11/10/1965]</p>		<p>8. PLACE OF DEATH [Handwritten: Home]</p>		<p>9. CAUSE OF DEATH [Handwritten: Heart Disease]</p>	
<p>10. MEDICAL HISTORY [Handwritten: Hypertension, Diabetes]</p>		<p>11. PRESENT ILLNESS [Handwritten: Anginal Pectoris]</p>		<p>12. TREATMENT [Handwritten: Medical, Surgical]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]</p>		<p>14. SIGNATURE OF WITNESSES [Handwritten: J. Doe, J. Doe]</p>		<p>15. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 BOSTON, MASS.
 1965

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00133

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1988 West St.</u>				d. STREET ADDRESS <u>1988 West St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>GALLAWAY</u> Last <u>GROSS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14 - 1908</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>RICHARD GALLAWAY</u>				14. MOTHER'S MAIDEN NAME <u>JANIE BUTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-303434</u>		17. INFORMANT <u>ETHEL G. CARTER - 1951 West St.</u>		Address <u>ANNAPOLIS-Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>Exhaustion of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Melanin fur Ca of Breast.</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>58</u> to <u>1/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/31</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>376 Calver Street</u> DATE SIGNED <u>George W.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOWLEYS</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate Rd. A.A.Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS III</u>				ADDRESS <u>ANNAPOLIS-Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kana</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00134

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>AACo</u> 157 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AAco</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roxol.</u>		c. LENGTH OF STAY IN 1b <u>Evergreen, West River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>DOMENICA</u> First <u>Muchaling</u> Middle <u>GUY</u> Last <u>MINNIE D.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1916</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW JERSEY</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ralph SPINO</u>		14. MOTHER'S MAIDEN NAME <u>Carmella Luatrano</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Barnington Guy, West River, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>1:15</u> 19 <u>59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>AAco MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Inhardt</u>		DATE SIGNED <u>1/16/59</u>	
EXAMINER'S NAME (Type) <u>E. L. Inhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Catherine</u>		22d. LOCATION (City, town, or county) (State) <u>Spring Lake NJ</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benedict Hardisty</u>		ADDRESS <u>Salisbury, Md</u>	
24a. REC'D BY REGISTRAR <u>Jan 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00134

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Physician		11. Signature of Nurse		12. Signature of Witness	
13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Cemetery		16. Signature of Registrar	
17. Signature of Health Officer		18. Signature of Police Officer		19. Signature of Fire Department		20. Signature of Other	
21. Signature of Other		22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other		28. Signature of Other	
29. Signature of Other		30. Signature of Other		31. Signature of Other		32. Signature of Other	
33. Signature of Other		34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other	
45. Signature of Other		46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other		52. Signature of Other	
53. Signature of Other		54. Signature of Other		55. Signature of Other		56. Signature of Other	
57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other	
65. Signature of Other		66. Signature of Other		67. Signature of Other		68. Signature of Other	
69. Signature of Other		70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other		76. Signature of Other	
77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other		88. Signature of Other	
89. Signature of Other		90. Signature of Other		91. Signature of Other		92. Signature of Other	
93. Signature of Other		94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

REMARKS: (To be filled in by the Medical Examiner or Coroner)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00135

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

A.A. Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL-

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MD

b. COUNTY AA Co

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Evergreen, West River

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☒ NO ☐3. NAME OF
DECEASED
(Type or print)LESSETTA Antonette DOMENICA LEUY
Lisetta A. 9044. DATE
OF
DEATH

Month 1 Day 15 Year 1959

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug 14, 1941

9. AGE (in years
last birthday)

17 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Spring Lake, N.J.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Barrington Leuy

14. MOTHER'S MAIDEN NAME

DOMENICA M. SPINO

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Barrington Leuy West River, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

825X

DUE TO

Multiple Injuries

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Auto accident

20c. TIME OF INJURY

Month, Day, Year

Hour

p. m. 1.15 1959

20d. INJURY OCCURRED

While of work ☐ Not while of work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Highway

20f. (City or town)

(County)

(State)

AA Co

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

E. Linhardt

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

1/16/59

EXAMINER'S
NAME (Type)

E. Linhardt

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/16/59

22c. NAME OF CEMETERY OR CREMATORY

St. Catherine N.J.

22d. LOCATION (City, town, or county)

Spring Lake N.J.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Bernard Hardisty Salvatore

ADDRESS

24a. REC'D BY REGISTRAR

JAN 26 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Hanna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH OFF
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION	
10. PRESENT ADDRESS		11. DATE OF DEATH		12. TIME OF DEATH	
13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER	
19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE		21. SIGNATURE OF CLERK	
22. SIGNATURE OF SHERIFF		23. SIGNATURE OF DEPUTY SHERIFF		24. SIGNATURE OF CONSTABLE	
25. SIGNATURE OF JAILER		26. SIGNATURE OF PRISONER		27. SIGNATURE OF GUARD	
28. SIGNATURE OF WARDEN		29. SIGNATURE OF CHIEF CLERK		30. SIGNATURE OF ASSISTANT CLERK	
31. SIGNATURE OF RECEPTIONIST		32. SIGNATURE OF TELEPHONE OPERATOR		33. SIGNATURE OF MAIL ROOM	
34. SIGNATURE OF JANITOR		35. SIGNATURE OF NIGHT WATCHMAN		36. SIGNATURE OF PORTER	
37. SIGNATURE OF CLEANER		38. SIGNATURE OF COOK		39. SIGNATURE OF BUTLER	
40. SIGNATURE OF HOUSEKEEPER		41. SIGNATURE OF GARDENER		42. SIGNATURE OF CARPENTER	
43. SIGNATURE OF PAINTER		44. SIGNATURE OF ELECTRICIAN		45. SIGNATURE OF PLUMBER	
46. SIGNATURE OF MECHANIC		47. SIGNATURE OF TAILOR		48. SIGNATURE OF HAT MAKER	
49. SIGNATURE OF SHOEMAKER		50. SIGNATURE OF JEWELER		51. SIGNATURE OF OPTICIAN	
52. SIGNATURE OF BARBER		53. SIGNATURE OF BEAUTICIAN		54. SIGNATURE OF HAIR DRESSER	
55. SIGNATURE OF MAKEUP ARTIST		56. SIGNATURE OF STYLIST		57. SIGNATURE OF MANICURIST	
58. SIGNATURE OF PEDICURIST		59. SIGNATURE OF NAIL TECHNICIAN		60. SIGNATURE OF COSMETOLOGIST	
61. SIGNATURE OF HAIR STYLIST		62. SIGNATURE OF HAIR DESIGNER		63. SIGNATURE OF HAIR ARTIST	
64. SIGNATURE OF HAIR CUTTER		65. SIGNATURE OF HAIR COLORIST		66. SIGNATURE OF HAIR TREATMENT SPECIALIST	
67. SIGNATURE OF HAIR STYLING SPECIALIST		68. SIGNATURE OF HAIR DESIGNER		69. SIGNATURE OF HAIR ARTIST	
70. SIGNATURE OF HAIR CUTTER		71. SIGNATURE OF HAIR COLORIST		72. SIGNATURE OF HAIR TREATMENT SPECIALIST	
73. SIGNATURE OF HAIR STYLING SPECIALIST		74. SIGNATURE OF HAIR DESIGNER		75. SIGNATURE OF HAIR ARTIST	
76. SIGNATURE OF HAIR CUTTER		77. SIGNATURE OF HAIR COLORIST		78. SIGNATURE OF HAIR TREATMENT SPECIALIST	
79. SIGNATURE OF HAIR STYLING SPECIALIST		80. SIGNATURE OF HAIR DESIGNER		81. SIGNATURE OF HAIR ARTIST	
82. SIGNATURE OF HAIR CUTTER		83. SIGNATURE OF HAIR COLORIST		84. SIGNATURE OF HAIR TREATMENT SPECIALIST	
85. SIGNATURE OF HAIR STYLING SPECIALIST		86. SIGNATURE OF HAIR DESIGNER		87. SIGNATURE OF HAIR ARTIST	
88. SIGNATURE OF HAIR CUTTER		89. SIGNATURE OF HAIR COLORIST		90. SIGNATURE OF HAIR TREATMENT SPECIALIST	
91. SIGNATURE OF HAIR STYLING SPECIALIST		92. SIGNATURE OF HAIR DESIGNER		93. SIGNATURE OF HAIR ARTIST	
94. SIGNATURE OF HAIR CUTTER		95. SIGNATURE OF HAIR COLORIST		96. SIGNATURE OF HAIR TREATMENT SPECIALIST	
97. SIGNATURE OF HAIR STYLING SPECIALIST		98. SIGNATURE OF HAIR DESIGNER		99. SIGNATURE OF HAIR ARTIST	
100. SIGNATURE OF HAIR CUTTER		101. SIGNATURE OF HAIR COLORIST		102. SIGNATURE OF HAIR TREATMENT SPECIALIST	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00137

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

AA CO

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MD

b. COUNTY

AA CO

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Evergreen - West River

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

ANNE ARUNDEL.

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☒ NO ☐3. NAME OF
DECEASED
(Type or print)

MARISA

First CARMELIA Middle LUY

Last

4. DATE
OF
DEATH

Month

Day

Year

MACISSA

904

1

15

1959

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

May 7 1955

9. AGE (In years
last birthday)

7 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Spring Lake, N.J.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Barrington LUY

14. MOTHER'S MAIDEN NAME

DOMENICA M. SPINO

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

N/O

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Barrington Luy West River Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

825X

DUE TO

Basilar Fracture Skull

INTERVAL BETWEEN
ONSET AND DEATH
3.5 hrs.Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Auto accident

20c. TIME OF INJURY

Month, Day, Year

Hour

p. m.

1.11

1959

20d. INJURY OCCURRED

While

at work ☐

Not while

at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Highway

20f. (City or town)

(County)

(State)

AA CO

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

[Signature]

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

E. L. Lohrhardt

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

1.11.59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/20/59

22c. NAME OF CEMETERY OR CREMATORY

St Catherine

22d. LOCATION (City, town, or county)

Spring Lake, N.J.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Bernard Harshbarger

ADDRESS

24a. REC'D BY REGISTRAR

DATE JAN 26 '59

24b. REGISTRAR'S SIGNATURE

Arthur L. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

159 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1016 Fitzallen Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS STRATTON HARTMAN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medien Const. Co</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Janner / Sailor</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Barber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>135-01-380</u>	
17. INFORMANT <u>Mrs Edna Hartman - 1016 Fitzallen Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>50</u> , to <u>Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>CB MacDonald MD</u> M.D.		ADDRESS (Street, city or town, state) <u>204 Crown Hwy Glen Burnie 1-6-59</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-6-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London PK.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes 130 E Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William A. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

00134

Date of Birth

Signature

Place of Birth

Age

Sex

Occupation

Place of Death

Cause of Death

Time of Death

Place of Burial

Place of Interment

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Funeral Director

Signature of Undertaker

Signature of Burial Society

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Interment

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

115

CERTIFICATE OF DEATH

Reg. Dist. No.

00136

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S.N. Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>1028 Forest Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>(n)</u> Last <u>HARMER</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep 4, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Issac (n) ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>Lucy (n) GAVIHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>- - -</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>493X</u> DUE TO (c) <u>493X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA of Liver</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 1 week</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 January, 19 59</u> , to <u>21 January, 19 59</u> , that I last saw the deceased alive on <u>21 January, 19 59</u> , and that death occurred at <u>11:35P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>R. J. BUSSE, JR.</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>DR. J. MILLER LEVINSKY</u>		USNH, Annapolis, Maryland 1-22-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>42 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DEBORAH</u> Middle <u>(N)</u> Last <u>HARTLEY</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 January 1959</u>		9. AGE (In years last birthday) yrs. <u>42</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Paul James HARTLEY</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Marie LAUBE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANENCEPHALY</u> <u>750x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>42 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12 January, 1959</u> to <u>12 January, 1959</u> , that I last saw the deceased alive on <u>12 January, 1959</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE: <u>F. M. KENNY</u> M.D.				U.S. Naval Hospital, Annapolis, Md. 1-13-59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NAVAL ACADEMY CEMET.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPKINS FUNERAL HOME</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harrison T. Hawkins</i> First Middle Last		4. DATE OF DEATH Month <i>1</i> Day <i>31</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-8-1889</i> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Nathaniel Hawkins</i>		14. MOTHER'S MAIDEN NAME <i>Galliana Spriggs</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>Rosie Winfield Hill Odenton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Cardiac Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiac Vascular Disease</i> DUE TO <i>10 yr</i> (c) <i>10 yr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>10 yr</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/30</i> , 19 <i>59</i> , to <i>2/31</i> , 19 <i>59</i> that I last saw the deceased alive on <i>1/31</i> , 19 <i>59</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>326 E. 1st St. Annapolis Md.</i> DATE SIGNED <i>Dr THEOPHRE H. JOHNSON M.D.</i>			
ACTUAL SIGNATURE <i>Dr THEOPHRE H. JOHNSON M.D.</i>		PHYSICIAN'S NAME (Type) <i>Dr THEOPHRE H. JOHNSON M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-6-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Sabor</i>	22d. LOCATION (City, town, or county) (State) <i>Chesterfield Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese #108 Wash. St. Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 5 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

County of ... State of Texas
 I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of ... State of Texas.

Witness my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 1877.

My Comm. Expires ...

Attest my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 1877.

My Comm. Expires ...

Attest my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 1877.

My Comm. Expires ...

Attest my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 1877.

My Comm. Expires ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00141

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
c. LENGTH OF STAY IN lb Few Minutes		d. STREET ADDRESS Spring Road, Rt. 6, Box 186	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Smallwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael James Healy		4. DATE OF DEATH Jan. 24 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1900
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY USA	
15. FATHER'S NAME William J. Healy		16. MOTHER'S MAIDEN NAME Margaret Harrison	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. INFORMANT Mrs. Mary E. Healy		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Internal Injuries and Crushed Chest DUE TO (c) Compound Fractures left leg			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident - into rear of oil truck	
20c. TIME OF INJURY Month, Day, Year Jan. 24, 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Pasadena, A.A. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 24, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley		ADDRESS Glen Burnie	
24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

161

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis (Rural)</u>				c. LENGTH OF STAY IN 1b <u>4 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cape St. John R.F.D.1 Box 59</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Hines</u> Last <u>Hines</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		11. BIRTHPLACE (State or foreign country) <u>Youngstown, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Youngstown, Ohio</u>			
13. FATHER'S NAME <u>Michael Hines</u>				14. MOTHER'S MAIDEN NAME <u>Katherine McKay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Alice M. Hines (Wife) Same as above</u>			
17. INFORMANT <u>Alice M. Hines (Wife) Same as above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>INAMINATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF STOMACH, METASTATIC</u> DUE TO <u>4 YRS</u> (c) <u>4 YRS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 YRS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>27 JAN., 1959</u> , to <u>31 JAN., 1959</u> , that I last saw the deceased alive on <u>27 JAN., 1959</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. <u>4/13/59</u>				ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>			
DATE SIGNED <u>1/31/59</u>				PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Youngstown, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>mt. Rainier Ind.</u>			
DATE <u>FEB 3 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a letter from the author to the editor, dated 10/10/1961. The letter discusses the author's interest in the subject of the journal and the importance of the research. The author mentions that the research was conducted in the laboratory of the author's father, who was a prominent figure in the field. The author also mentions that the research was supported by the National Science Foundation. The letter concludes with a request for the editor to publish the paper in the journal.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne A undel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 17y 3m 18d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel d. STREET ADDRESS Box 24 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melvin Middle Horsey Last Horsey		4. DATE OF DEATH Month 1 Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1903
9. AGE (In years lost birthday) yrs. 55		IF UNDER 1 YEAR Months 1 Days 22 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Horsey		14. MOTHER'S MAIDEN NAME Lizzie Carvin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration DUE TO (c) Inanition PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized and cerebral			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/4 , 19 41 to 1/22 , 19 59 , that I last saw the deceased alive on 1/22 , 19 59 , and that death occurred at 10:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/22/59 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 1/22/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 26, 1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Clifton Mt		22d. LOCATION (City, town, or county) (State) Clifton Talbot Co	
23. FUNERAL DIRECTOR'S SIGNATURE Norman S. Marshfield		ADDRESS Clifton Talbot Co	
24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE

TIME

PLACE

CAUSE

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

STATUS

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

STATUS

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

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PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

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TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

STATUS

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00144

Reg. Dist. No.

118

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General Hospital</u>		d. STREET ADDRESS <u>65 Larkin Street</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur</u> First <u>Howard</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1903</u> 35 yrs.
9. AGE (in years last birthday) <u>35</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u> Hours <u>12</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asbury Howard</u>		14. MOTHER'S MAIDEN NAME <u>Hertie Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mary Chase 65 Larkin St.</u>	
17. INFORMANT <u>Mary Chase 65 Larkin St.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2-3rd. Burns entire body</u> <u>916.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>916.5</u> DUE TO (c) <u>916.5</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>916.5</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Built fire in wheelbarrow & clearing caught fire</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:15</u> p. m. <u>11:19</u> 1958		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>W. WINDMILL STREET</u>		20f. (City or town) <u>AACU</u> (County) <u>MD.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. N. H. H. H.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. N. H. H. H.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. Annapolis</u>		24. REC'D BY REGISTRAR <u>JAN 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00145

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ad. General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Florence Luvenia Howard</u>		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Work Naval Academy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Wesley Pickford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Agnes L. Mack</u>		Address <u>Harwood Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Stroke</u> (c) <u>underlying</u> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Hawk</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keese</u>		ADDRESS <u>108 Wash St. Anna Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	
DATE <u>JAN 26 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00146

163
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Marie Ave				d. STREET ADDRESS 205 Marie Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Olivia Middle Doe Last Howe				4. DATE OF DEATH Month Jan. Day 30 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1870		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Martin Green				14. MOTHER'S MAIDEN NAME ? Hooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. *****		17. INFORMANT Address Mrs Wilbur Stevenson, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Arteriosclerosis 450.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Over 3 years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from October 1956 , to January 30th 1959 , that I last saw the deceased alive on January 30th, 1959 , and that death occurred at 7.15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Glen Burnie, Md. 1/31/59 PHYSICIAN'S NAME (Type) G. H. Faubert, M.D. 5 1st Ave SE, Glen Burnie, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/59		22c. NAME OF CEMETERY OR CREMATORY St. Stephens		22d. LOCATION (City, town, or county) (State) Millersville, AA Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Hopping and Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE FEB 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00147

Reg. Dist. No.

164

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u> c. LENGTH OF STAY IN lb <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Parlway Manor</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maine</u> b. COUNTY <u>Mars Hill</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXXX Mars Hill</u> d. STREET ADDRESS <u>Gilman St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs Pauline Olive Hunter</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19th</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/18/06</u>	
9. AGE (in years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>		11. BIRTHPLACE (State or foreign country) <u>Easton, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George Calbath</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Falls</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Hunter (Husband)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>904.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 years.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Probably had fainting spell and fell in the bathtub.</u>					
20c. TIME OF INJURY Month, Day, Year <u>2.30</u> a.m. <u>1/19/59</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parkway Manor Motel</u>		20f. (City or town) (County) (State) <u>Jessups, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/19/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>1/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pierce Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mars Hill, Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF DEATH: _____

5. TIME OF DEATH: _____

6. PLACE OF DEATH: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF EXAMINER: _____

10. OFFICE OF EXAMINER: _____

11. COUNTY OF DEATH: _____

12. STATE OF DEATH: _____

13. CITY OF DEATH: _____

14. ZIP CODE: _____

15. TELEPHONE: _____

16. FAX: _____

17. E-MAIL: _____

18. OTHER: _____

SD 6-2200

CERTIFICATE OF DEATH

Reg. Dist. No.

120

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>				e. STREET ADDRESS <u>Rt. 9-Box 476-Chesnut-Mulberry St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William T</u> Middle <u>Jenkins</u> Last <u>Jenkins</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-8-90</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.Co. md.</u>		11. BIRTHPLACE (State or foreign country) <u>A.A.Co. md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James A. Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Emma Mook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-526313</u>			
17. INFORMANT Address <u>Mrs. Edith L. Jenkins - Same as No #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System collapse</u> 560.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema</u> DUE TO <u>cardiac arrest during surgery</u> (c) <u>for left inguinal hernia (gen) anesthesia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>8 hrs.</u> <u>10 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None known</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 7, 1959</u> to <u>Jan. 8, 1959</u> , that I last saw the deceased alive on <u>Jan. 9, 1959</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis Md</u> DATE SIGNED <u>1-8-59</u>							
ACTUAL SIGNATURE <u>Merton T. Waite</u> M.D.				PHYSICIAN'S NAME (Type) <u>MERTON T. Waite M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenn Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glenn Burnie - md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Singleton</u> ADDRESS <u>1111 N. ...</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

165
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 13 yr. 10 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center				d. STREET ADDRESS 3620 N Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle Johnson Last Johnson				4. DATE OF DEATH Month January Day 20 Year 1959			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1941		9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lester Johnson				14. MOTHER'S MAIDEN NAME Corrine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT District Training School Children's Center, Laurel, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status epilepticus 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis. (c) Chronic epilepsy.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, unskilled, spastic diplegia.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3/9/45 , 19____, to 1/20/59 , 19____, that I last saw the deceased alive on 1/20/59 , 19____, and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) District Training School Children's Center Laurel, Md. DATE SIGNED 1/21/59							
ACTUAL SIGNATURE Margaret W. Mola M.D.				PHYSICIAN'S NAME (Type) Margaret W. Mola, M.D.			
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF Jan. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY District Training School		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Moore, Jr. ADDRESS District Training School Laurel, Maryland				24a. REC'D BY REGISTRAR DATE JAN 28 '59		24b. REGISTRAR'S SIGNATURE Robert S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Rebecca Johnson</i>		4. DATE OF DEATH Month Day Year <i>1 - 13 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-9-1898</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Allen</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Porter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Margarett Johnson Skidmore Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Insufficiency following</i> <i>416X</i> DUE TO <i>Rheumatic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 1 - 1958</i> to <i>1-13-1959</i> , that I last saw the deceased alive on <i>1-13-1959</i> , and that death occurred at <i>5:25 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Reichen</i>		ADDRESS (Street, city or town, state) <i>110 - 019 St ANNAPOLIS Md.</i> DATE SIGNED <i>1/15/59</i>	
PHYSICIAN'S NAME (Type) <i>Wm. Reese</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-18-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	22d. LOCATION (City, town, or county) (State) <i>Skidmore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese #108 Wash. St. Annapolis</i>		24a. REC'D BY REGISTRAR <i>JAN 15 1959</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-1-1991

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>				c. LENGTH OF STAY IN 1b <u>420.0</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>216 Riverside Rd</u>				d. STREET ADDRESS <u>1 216 Riverside Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>KANE</u>				4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 17, 1923</u>		9. AGE (In years lost birthday) <u>35</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home - Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Flora Kane</u>			
14. MOTHER'S MAIDEN NAME <u>Bridget</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Family</u> Address <u>Jane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.0</u> DUE TO <u>Senility</u> (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Senility</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <u>Jane</u> , 1957, to <u>Jane</u> , 30, 1959, that I last saw the deceased alive on <u>Jan 30</u> , 1959, and that death occurred of <u>7:30 PM</u> , from the causes and on the date stated above.	
21. ACTUAL SIGNATURE <u>P. J. Grimaldi</u>		21. DATE SIGNED <u>1-31-59</u>		21. ADDRESS (Street, city or town, State) <u>4609 Gov. Ritchie Hwy</u>		21. PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hanover, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes 130 E Fort Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A.A.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE				c. LENGTH OF STAY IN 1b 5 wks 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SANN'S NURSING HOME				1 d. STREET ADDRESS 507 FIRST AVE. S.W.			
3. NAME OF DECEASED (Type or print) WEBSTER First C. Middle KEITHLEY Last				4. DATE OF DEATH JANUARY 12 1959 Month 12 Day 19 Year 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baggage Man - Railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Michael, Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN KEITHLEY				14. MOTHER'S MAIDEN NAME REBECCA FAIRBANKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-07-4870		17. INFORMANT MARY WILLIAMS Address MILLERSVILLE, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pulmonary Edema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-4-58 19, to Jan 12, 1959 , that I last saw the deceased alive on Jan 2, 1959 , and that death occurred at — M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Lipsky M.D.				DATE SIGNED Jan 19 59			
PHYSICIAN'S NAME (Type) JOSEPH LIPSKEY - ODETON, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-59		22c. NAME OF CEMETERY OR CREMATORY Balte Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Hambleton Harrison ADDRESS St. Michael				24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

#102943 The deceased named above was buried in the cemetery named in item 22c. Burial was in Section Spruce Lot.No.639 Grave No.3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page One, Two

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. DATE OF BIRTH 12-11-1928		4. PLACE OF BIRTH MOBILE, ALABAMA	
5. OCCUPATION Author		6. MARITAL STATUS Single	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide	
9. PLACE OF DEATH Room 936, Lorraine Hotel, Memphis, Tennessee		10. TIME OF DEATH 4:30 PM	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES JAMES EARL RAY	
13. SIGNATURE OF PHYSICIAN JAMES EARL RAY		14. SIGNATURE OF CORONER JAMES EARL RAY	
15. SIGNATURE OF JURY JAMES EARL RAY		16. SIGNATURE OF JUDGE JAMES EARL RAY	
17. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		18. SIGNATURE OF CLERK JAMES EARL RAY	
19. SIGNATURE OF SHERIFF JAMES EARL RAY		20. SIGNATURE OF JAILER JAMES EARL RAY	
21. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		22. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
23. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		24. SIGNATURE OF CLERK JAMES EARL RAY	
25. SIGNATURE OF SHERIFF JAMES EARL RAY		26. SIGNATURE OF JAILER JAMES EARL RAY	
27. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		28. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
29. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		30. SIGNATURE OF CLERK JAMES EARL RAY	
31. SIGNATURE OF SHERIFF JAMES EARL RAY		32. SIGNATURE OF JAILER JAMES EARL RAY	
33. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		34. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
35. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		36. SIGNATURE OF CLERK JAMES EARL RAY	
37. SIGNATURE OF SHERIFF JAMES EARL RAY		38. SIGNATURE OF JAILER JAMES EARL RAY	
39. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		40. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
41. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		42. SIGNATURE OF CLERK JAMES EARL RAY	
43. SIGNATURE OF SHERIFF JAMES EARL RAY		44. SIGNATURE OF JAILER JAMES EARL RAY	
45. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		46. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
47. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		48. SIGNATURE OF CLERK JAMES EARL RAY	
49. SIGNATURE OF SHERIFF JAMES EARL RAY		50. SIGNATURE OF JAILER JAMES EARL RAY	
51. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		52. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
53. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		54. SIGNATURE OF CLERK JAMES EARL RAY	
55. SIGNATURE OF SHERIFF JAMES EARL RAY		56. SIGNATURE OF JAILER JAMES EARL RAY	
57. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		58. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
59. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		60. SIGNATURE OF CLERK JAMES EARL RAY	
61. SIGNATURE OF SHERIFF JAMES EARL RAY		62. SIGNATURE OF JAILER JAMES EARL RAY	
63. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		64. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
65. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		66. SIGNATURE OF CLERK JAMES EARL RAY	
67. SIGNATURE OF SHERIFF JAMES EARL RAY		68. SIGNATURE OF JAILER JAMES EARL RAY	
69. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		70. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
71. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		72. SIGNATURE OF CLERK JAMES EARL RAY	
73. SIGNATURE OF SHERIFF JAMES EARL RAY		74. SIGNATURE OF JAILER JAMES EARL RAY	
75. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		76. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
77. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		78. SIGNATURE OF CLERK JAMES EARL RAY	
79. SIGNATURE OF SHERIFF JAMES EARL RAY		80. SIGNATURE OF JAILER JAMES EARL RAY	
81. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		82. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
83. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		84. SIGNATURE OF CLERK JAMES EARL RAY	
85. SIGNATURE OF SHERIFF JAMES EARL RAY		86. SIGNATURE OF JAILER JAMES EARL RAY	
87. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		88. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
89. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		90. SIGNATURE OF CLERK JAMES EARL RAY	
91. SIGNATURE OF SHERIFF JAMES EARL RAY		92. SIGNATURE OF JAILER JAMES EARL RAY	
93. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		94. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	
95. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		96. SIGNATURE OF CLERK JAMES EARL RAY	
97. SIGNATURE OF SHERIFF JAMES EARL RAY		98. SIGNATURE OF JAILER JAMES EARL RAY	
99. SIGNATURE OF PRISON WARDEN JAMES EARL RAY		100. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY	

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100-443001

CERTIFICATE OF DEATH

00153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marley, Glen Burnie		c. LENGTH OF STAY IN 1b 60 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rte. 1, Box 335		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marley, Glen Burnie	
d. STREET ADDRESS Rte. 1, Box 335		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Greenfield Last Lamb		4. DATE OF DEATH Month Jan. Day 11, Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1863
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Mary Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. William Lamb, same as 2	
17. INFORMANT Address Mr. William Lamb, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 2, 1959 , to Jan 11, 1959 , that I last saw the deceased alive on Jan 10, 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James S. Billingslea M.D.			
PHYSICIAN'S NAME (Type) James S. Billingslea, M.D. 108 Central Ave, Glen Burnie			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Charles S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 3 be

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CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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ISM 10/57

1. PLACE OF DEATH o. COUNTY A.A. Co		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md b. COUNTY A.A. Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE RT 1 Box 9A	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakwood Rd		d. STREET ADDRESS 10 Oakwood Rd	
3. NAME OF DECEASED (Type or print) William H. Milton Hankau		4. DATE OF DEATH January 12 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 90EX 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sup		10b. KIND OF BUSINESS OR INDUSTRY Whl' Grocey	
11. BIRTH PLACE (State or foreign country) BALTO md		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME John W. Hankau		14. MOTHER'S MAIDEN NAME KATHERINE P. LANG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 712-07-875	
17. INFORMANT EVAM. SCHOEN		Address OAKWOOD Rd GLEN BURNIE RT 1 Box 9A	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Cardiac Failure DUE TO (b) Cardiovascular Renal Disease DUE TO (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10 , 19 57 , to 1/12 , 19 59 , that I last saw the deceased alive on 1/12 , 19 59 , and that death occurred at 6A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Hankau		DATE SIGNED 1/13	
PHYSICIAN'S NAME (Type) JOSEPH G. HANKAU M.D.		ADDRESS (Street, city or town, state) 679 Washington Blvd Baltimore	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 15 JAN 1959	
22c. NAME OF CEMETERY OR CREMATORY HOODON PARK CEM		22d. LOCATION (City, town, or county) (State) BALTO md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. M. Walters		24a. REC'D BY REGISTRAR Arthur S. Harris	
ADDRESS PRATT & STRICKER		DATE JAN 14 '59	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

STATE OF MASSACHUSETTS
BUREAU ONE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EDWARD		45		M		W		1905		NEW YORK		NEW YORK		UNITED STATES	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
123 MAIN ST.		LABORER		HEART DISEASE		NATURAL		1950		HOSPITAL		BOSTON		MASSACHUSETTS	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE	
JOHN J.		MARY J.		ANNE		JOHN		HIGH SCHOOL		CATHOLIC		DEMOCRAT		NONE	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
1950		J. J. J.													

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

170 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A.A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE				c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAYO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SANN'S NURSING HOME				d. STREET ADDRESS MAYO, Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLEN R. LEE				4. DATE OF DEATH Month Day Year JANUARY 19 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 5, 1873	
9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAMUEL C. BULLEN				14. MOTHER'S MAIDEN NAME SOSAN PURDY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		INFORMANT Mary J. Williams, Millersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 352x Acute Lobar Pneumonia DUE TO (b) Bilateral Hemiplegia - Radius 1 1/2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Cardio Vasc. D. - Cerebral Infarct.				INTERVAL BETWEEN ONSET AND DEATH 2 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vasc. D. - Cerebral Infarct.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Jan 14-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 14-59 to Jan 19-59 , that I last saw the deceased alive on Jan 18-59 , and that death occurred at 3:15 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Odenton, Md. DATE SIGNED Jan 19-59			
ACTUAL SIGNATURE DR. JOSEPH LIPSKEY M.D.				PHYSICIAN'S NAME (Type) ODENTON, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-59		22c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemt		22d. LOCATION (City, town, or county) (State) Mayo Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Suss ADDRESS Chesapeake Md				24a. REC'D BY REGISTRAR DATE 21 '59		24b. REGISTRAR'S SIGNATURE Charles E. Knead	

THE STATE OF TEXAS,
COUNTY OF DALLAS.I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.WITNESSED my hand and the seal of said County, at Dallas, Texas, this 1st day of May, 1900.Clerk of the County of Dallas, Texas.[Signature]

171
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riviera Beach</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riviera Beach</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harlem Rd.</i>				d. STREET ADDRESS <i>Harlem Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Lynch</i> Last <i>Lynch</i>				4. DATE OF DEATH Month <i>1-9</i> Day <i>-</i> Year <i>1959</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 4, 1886</i>	9. AGE (In years last birthday) <i>72</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>Inman</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Family - Same</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Ovary with</i> <i>1750</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>undiscovered metastasis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1/2</i> , 19 <i>59</i> , to <i>1/9</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1/9</i> , 19 <i>59</i> , and that death occurred at <i>9:00</i> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Morton M. Krieger</i> M.D.				ADDRESS (Street, city or town, state) <i>50106 Ritchie Hwy Balto. 25, Md.</i>			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1-11-1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Family Plot</i>		22d. LOCATION (City, town, or county) (State) <i>Orange, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home - 1306 Tontine</i>				24a. REC'D BY REGISTRAR <i>JAN 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

WILLIAM BOND
JAMES A. JONES

NAME OF DECEASED		DATE OF DEATH	
WILLIAM BOND		JANUARY 1, 1918	
AGE		SEX	
45		Male	
RACE		COLOR	
White		White	
BIRTHPLACE		RESIDENCE	
Maryland		Baltimore, Maryland	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
EDUCATION		MANNER OF DEATH	
High School		Natural	
RELIGION		PLACE OF DEATH	
Roman Catholic		Home	
MARITAL STATUS		DATE OF BIRTH	
Married		JANUARY 1, 1873	
NAME OF SPOUSE		NAME OF FATHER	
JAMES BOND		JOHN BOND	
NAME OF MOTHER		NAME OF DOCTOR	
MARY BOND		DR. J. H. JONES	
NAME OF MINISTER		NAME OF BURIAL PLACE	
FRANK JONES		CATHOLIC CHURCH	
NAME OF FUNERAL HOME		NAME OF CEMETERY	
JOHN JONES		CATHOLIC CHURCH	
NAME OF INTERVIEWER		NAME OF REGISTRAR	
JOHN JONES		JOHN JONES	

RECORDS SECTION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00157

172 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		c. LENGTH OF STAY IN It	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Maynard</i> Last <i>Maynard</i>		4. DATE OF DEATH Jan. 29 1959	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 11 1920</i>
9. AGE (In years last birthday) <i>38</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Arnold Md</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Albert Maynard</i>		14. MOTHER'S MAIDEN NAME <i>Daisy Maynard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William H. Miller, Arnold Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Virus Pneumonia</i> <i>492X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/28</i> , 1959, to <i>1/29</i> , 1959, that I last saw the deceased alive on <i>1/29</i> , 1959, and that death occurred at <i>A. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i>		ADDRESS (Street, city or town, state) <i>37 Calvert Street, Annapolis, Md</i>	
PHYSICIAN'S NAME (Type) <i>Dr THEODORE H. JOHNSON</i>		DATE <i>Feb 3 '59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Feb 11 1959</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary</i>		22d. LOCATION (City, town, or county) (State) <i>Arnold Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Annie F. Johnson</i>		24a. REC'D BY REGISTRAR <i>Feb 3 '59</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE

CAUSE OF DEATH

DIAGNOSIS

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

AGE

SEX

RACE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00158

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN IB <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPINES ON THE SEVERN</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>S. MEIKLEJOHN SR.</u> Middle <u>John</u> Last		4. DATE OF DEATH <u>January 2 1959</u> Month <u>January</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-1902</u> 9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POWER PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William MEIKLEJOHN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA JACOBS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give year or dates of service) <u>1920-22</u>		16. SOCIAL SECURITY NO. <u>ROBERT S. MEIKLEJOHN</u> Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Coronary artery sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> 1959, to <u>Jan 2</u> 1959, that I last saw the deceased alive on <u>Jan 1</u> 1959, and that death occurred at <u>448</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John L. Holsman</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral</u> DATE SIGNED <u>1/3/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-6-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>	22d. LOCATION (City, town, or county) (State) <u>GLEN BURIE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor's Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 6 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grambrill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grambrill Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mentor Middle E. Mollohan Last		4. DATE OF DEATH Month Jan Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 26, 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Penna Railroad	
11. BIRTHPLACE (State or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel C Mollohan		14. MOTHER'S MAIDEN NAME Virginia Mc Cray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 717 07 8525	
17. INFORMANT Catherine Mollohan		Address Brentwood Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cancer of Prostate.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-2 , 19 59 to 1-17 , 19 59 that I last saw the deceased alive on 1-14 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 Gallatin St Hyattsville Md. DATE SIGNED 1/18/59 ACTUAL SIGNATURE Deitz M.D. PHYSICIAN'S NAME (Type) Deitz Hyattsville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/20/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR JAN 21 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CONNECTICUT, DEPARTMENT OF HEALTH—BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01459

174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 46yr.9mo.10da d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 1437.2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Morton Last Morton		4. DATE OF DEATH Month 1 Day 28 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 91 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 141.9 DUE TO Aspiration of food particles Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of tongue (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----	20d. INJURY OCCURRED While <input type="checkbox"/> not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from 4/18 , 19 12 , to 1/28 , 19 59 , that I last saw the deceased alive on 1/28 , 19 59 , and that death occurred at 12:25P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/29/59 ACTUAL SIGNATURE Lionel McHenry Wapp, M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Wapp, M.D. Crownsville State Hospital, Md. 1/29/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-6-59	22c. NAME OF CEMETERY OR CREMATORY Crownsville Hosp. Grounds, Crownsville, A.A.Co., Md.	22d. LOCATION (City, town, or county) (State) -----
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Howard Spink		24a. REC'D BY REGISTRAR DATE FEB 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Howard

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>13 N. Woodlawn Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWIN D MYERS</u>				4. DATE OF DEATH Month Day Year <u>January 24, 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1876</u>	
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>19 59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Police</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Myers</u>		14. MOTHER'S MAIDEN NAME <u>Rose Alvey MYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Spanish-American</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Geretrude Myers- Daughter- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVA</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>U.S.A.</u> <u>7+ yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>9-24, 1959</u> , that I last saw the deceased alive on <u>11-28, 1958</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>121 Cathedral St. - 1-27-59</u>			
PHYSICIAN'S NAME (Type) <u>Frank Shipley M.D.</u>				<u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

128

Reg. No. 100

<p>1. Name of deceased (Print name in full)</p>		<p>2. Sex</p>		<p>3. Race</p>		<p>4. Date of birth</p>		<p>5. Place of birth</p>	
<p>6. Usual residence (Street, city, county, State)</p>		<p>7. Date of death</p>		<p>8. Time of death</p>		<p>9. Cause of death (Immediate)</p>		<p>10. Cause of death (Underlying)</p>	
<p>11. Signature of physician (Print name and title)</p>		<p>12. Signature of registrar (Print name and title)</p>		<p>13. Signature of informant (Print name and title)</p>		<p>14. Signature of witness (Print name and title)</p>		<p>15. Signature of witness (Print name and title)</p>	
<p>16. Date of registration</p>		<p>17. Place of registration</p>		<p>18. County</p>		<p>19. State</p>		<p>20. City</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 10, SECTION 10-101, OF THE MARYLAND CODE, TITLE 10, SUBTITLE 1, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 10, SECTION 10-102, OF THE MARYLAND CODE, TITLE 10, SUBTITLE 1.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14, 15 Film G238 1-23-59 et

CERTIFICATE OF DEATH

00161

175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> <u>19X-2</u>			
c. LENGTH OF STAY IN 1b <u>11 mos. 24 days</u>				d. STREET ADDRESS <u>Crownsville State Hospital</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u>			First <u>Charles</u> Middle <u>Niskey</u> Last <u>Niskey</u>			4. DATE OF DEATH <u>January 14, 19 59</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1874</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Somerset Co., Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Niskey, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Hayman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>026X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Syphilis</u> DUE TO (c) <u>CNS Syphilis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 21, 19 58</u> to <u>January 14, 19 59</u> , that I last saw the deceased alive on <u>January 14, 19 59</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. <u>Crownsville, Maryland</u>				DATE SIGNED <u>9/14/59</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> <u>9/14/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 18-59</u>		22c. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Princess Anne Som, Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Word</u> ADDRESS <u>Marion Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

Am. 1176 - 1177

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
• MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00162

Reg. Dist. No.

176

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton	
c. LENGTH OF STAY IN 1b 5 mo		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BABY WANDA ANN OFFER		4. DATE OF DEATH Month Day Year January 5 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/58
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Annapolis Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME DONALD DANDRIDGE		14. MOTHER'S MAIDEN NAME Nettie Ann Offer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nettie A. Offer, Churchton Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis. 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIED		22b. DATE THEREOF 1/8/59	
22c. NAME OF CEMETERY OR CREMATORY FRANKLIN		22d. LOCATION (City, town, or county) (State) Churchton Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardaway		ADDRESS Beltsville Md	
24a. REC'D BY REGISTRAR DATE JAN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

2163192XV3

FOR STATE
HEALTH DEPT.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John Doe
AGE: 45 SEX: Male
RACE: White BIRTH DATE: 10/15/1910
PLACE OF BIRTH: New York City
OCCUPATION: Teacher
RESIDENCE: 123 Main St, New York City
DATE OF DEATH: 11/10/1955 TIME OF DEATH: 10:30 AM
PLACE OF DEATH: Home
CAUSE OF DEATH: Myocardial Infarction
MANNER OF DEATH: Natural
MEDICAL HISTORY: None
PREVIOUS ILLNESS: None
PREVIOUS SURGERY: None
PREVIOUS TRAUMA: None
PREVIOUS DRUGS: None
PREVIOUS ALCOHOL: None
PREVIOUS TOBACCO: None
PREVIOUS OTHER: None
FAMILY HISTORY: None
SOCIAL HISTORY: None
HISTORICAL DATA: None
PHYSICAL EXAMINATION: None
LABORATORY EXAMINATION: None
X-RAY EXAMINATION: None
AUTOPSY: None
SIGNATURE OF EXAMINER: [Signature]
DATE: 11/10/1955
OFFICE: New York City

BOND

TO BE FILLED BY THE EXAMINER
IF THE DECEASED WAS A RESIDENT OF THE STATE OF NEW YORK
AT THE TIME OF DEATH, THE EXAMINER SHALL SIGN THIS CERTIFICATE
AND RETURN IT TO THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK.
IF THE DECEASED WAS A NON-RESIDENT OF THE STATE OF NEW YORK
AT THE TIME OF DEATH, THE EXAMINER SHALL SIGN THIS CERTIFICATE
AND RETURN IT TO THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK.
IF THE DECEASED WAS A RESIDENT OF THE STATE OF NEW YORK
AT THE TIME OF DEATH, THE EXAMINER SHALL SIGN THIS CERTIFICATE
AND RETURN IT TO THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK.

177

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Henry Owens</u>		4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eliyah Owens</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Colbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or armed forces) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Owens</u>		Address <u>Harwood Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Hy-faltemia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Gate III</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15, 1958</u> to <u>Jan 28, 1959</u> , that I last saw the deceased alive on <u>Jan 28, 1959</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>118 - CHAPT. H. H. P. O. 615 19</u>	
ACTUAL SIGNATURE <u>John H. Owens</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-1-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Owensville Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keeseff</u> ADDRESS <u>108 W. 8th St. Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BATHING ORD. 10

ALBION

INFORMANT

DATE

PLACE

TIME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Meade		c. LENGTH OF STAY IN 1b 4 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Meade		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Civilian Dormitory			e. STREET ADDRESS Civilian Dormitory		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Stephan Stanley Pawlik			4. DATE OF DEATH Month Jan. Day 11, Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/13/14		9. AGE (in years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Ft. Meade		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Stanley Pawlik			14. MOTHER'S MAIDEN NAME Mary Sipniski		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 11 220-038556		17. INFORMANT Address Mr. Chester Pawlik, Millersville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) (c), stating the underlying cause lost. DUE TO (c) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/12/59	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 15/59		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.	
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Singleton		ADDRESS St. Bernard's Rd.		24a. REC'D BY REGISTRAR DATE JAN 19 1959	
24b. REGISTRAR'S SIGNATURE Arthur E. Kenna					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00165

1 179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROUND BAY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROUND BAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>223 Old County Road</u>				d. STREET ADDRESS <u>Old County Road</u>			
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>L.</u> Last <u>PIEHLER</u>				4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 24 - 1890</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St Paul Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Carl Tholander</u>				14. MOTHER'S MAIDEN NAME <u>Jula Matilda Benson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Harry P Leroy</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Chronic heart disease</u> DUE TO (c) <u>lying cause last.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mks</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>Jan 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. H. Druman</u>		M.D. <u>121 Centarchal</u>		DATE SIGNED <u>1/10/59</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lofgren & Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>			

00100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1875		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School		11. SOCIAL SECURITY NUMBER 1-123-456789		12. PLACE OF DEATH Home	
13. DATE OF DEATH 1940		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Heart Disease		16. MANNER OF DEATH Natural		17. PLACE OF INTERMENT St. Mary's Cemetery		18. NAME OF FUNERAL HOME John's Funeral Home	
19. SIGNATURE OF DECEASED James H. Harris		20. SIGNATURE OF WITNESS John's Funeral Home		21. SIGNATURE OF PHYSICIAN Dr. J. H. Harris		22. SIGNATURE OF CORONER John's Funeral Home		23. SIGNATURE OF CLERK John's Funeral Home		24. SIGNATURE OF JURY John's Funeral Home	
25. SIGNATURE OF DECEASED James H. Harris		26. SIGNATURE OF WITNESS John's Funeral Home		27. SIGNATURE OF PHYSICIAN Dr. J. H. Harris		28. SIGNATURE OF CORONER John's Funeral Home		29. SIGNATURE OF CLERK John's Funeral Home		30. SIGNATURE OF JURY John's Funeral Home	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. COLOR
9. RELIGION
10. EDUCATION
11. SOCIAL SECURITY NUMBER
12. PLACE OF DEATH
13. DATE OF DEATH
14. TIME OF DEATH
15. CAUSE OF DEATH
16. MANNER OF DEATH
17. PLACE OF INTERMENT
18. NAME OF FUNERAL HOME
19. SIGNATURE OF DECEASED
20. SIGNATURE OF WITNESS
21. SIGNATURE OF PHYSICIAN
22. SIGNATURE OF CORONER
23. SIGNATURE OF CLERK
24. SIGNATURE OF JURY
25. SIGNATURE OF DECEASED
26. SIGNATURE OF WITNESS
27. SIGNATURE OF PHYSICIAN
28. SIGNATURE OF CORONER
29. SIGNATURE OF CLERK
30. SIGNATURE OF JURY

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

4

124

W. T. PULLIAM

124

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville 03x-2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. Gen Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J.</u> Last <u>PULLIAM</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/29/16</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u> Hours <u>15</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>OSCAR H. PULLIAM</u>				14. MOTHER'S MAIDEN NAME <u>Sylvia Grim</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-05-5674</u>		17. INFORMANT Address <u>Edna Pulliam</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY THROMBOSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u> <u>1 HOUR</u> <u>12 HOURS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/18</u> , 19 <u>59</u> , to <u>1/18/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>59</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 South Gate AVE</u> DATE SIGNED <u>1/18/59</u> ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D. ANNAPOLIS, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/21/59</u>		<u>Balto National</u>		<u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Max Hall & Son</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01462

Items 20,21 Film 230 4-12-59 ams

Items 7,11,12,13,14 Film 238 2-16-59 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Tyler Box-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel Gen. Hosp.		d. STREET ADDRESS 718 E. Oakwood	
3. NAME OF DECEASED (Type or print) James Pyron		4. DATE OF DEATH Month January Day 28 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Tyler, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries with fracture of the neck. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 812X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto -- hit and run	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 p. m. 1/28/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	20f. (City or town) (County) (State) Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> January 29, 1959 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED	
22a. BURIAL-CREMATATION REMOVAL (Specify) 2.9.59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Calverton Wash. School	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE FEB 10 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

02

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00167

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN 1b Yrs. 50	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 240 Edgevale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE First E. Middle RAFFERTY Last		4. DATE OF DEATH 1/30/59 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/99
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Crato		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive cardio vascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19, 56 , to Jan 30, 19 59 , that I last saw the deceased alive on Jan 30, 19 59 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-31-59 DATE SIGNED			
ACTUAL SIGNATURE Philip W. Keister, M.D.		PHYSICIAN'S NAME (Type) KEISTER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/59	
22c. NAME OF CEMETERY OR CREMATORY National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		ADDRESS 130 E. Fort Ave.	
24a. REC'D BY REGISTRAR FEB 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

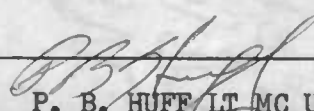

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00168

126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 0353.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.			d. STREET ADDRESS 7609 Charlesmont Rd.			
3. NAME OF DECEASED (Type or print) First James Middle LeRoy Last RICE			4. DATE OF DEATH Month Jan Day 26 Year 19 59			
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Mar 1955	9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- --		10b. KIND OF BUSINESS OR INDUSTRY -- --		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Robert Lee RICE			12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -- --			16. SOCIAL SECURITY NO. -- --			
17. INFORMANT U.S. Naval Hosp. Annapolis, Md.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart disease						INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County) (State)			
21. I certify that I attended the deceased from 25 Jan , 19 59 , to 26 Jan , 19 59 , that I last saw the deceased alive on 26 Jan , 19 59 , and that death occurred at 6:26A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S.N. Hosp. Annapolis, Md. DATE SIGNED 1-26-59						
ACTUAL SIGNATURE 			M.D. U.S.N. Hosp. Annapolis, Md.			
PHYSICIAN'S NAME (Type) P. B. HUFF LT MC USNR						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/59	22c. NAME OF CEMETERY OR CREMATORY Lutheren Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman			ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE 29 '59	
			24b. REGISTRAR'S SIGNATURE 			

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• <http://www.who.int>

517-21-1 (continued)

by *at present* and *now* David S. D.

Author's address: Department of Psychology, University of Illinois at Chicago, Chicago, IL 60607, USA.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A. A. County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A. A. County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn				c. LENGTH OF STAY IN 1b 50 Brooklyn 25			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 18 Wallis Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First OSCEOLA Middle A. Last ROSS				4. DATE OF DEATH Month January Day 1 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (Ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Zell Motor Co		11. BIRTHPLACE (State or foreign country) Pitt County, N. Car.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John S. Ross				14. MOTHER'S MAIDEN NAME Pattie Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ava Ross			Address 18 Wallis Ave. Brooklyn 25 Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X Stroke DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Branch Pneumonia DUE TO 6 days (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 59 to 19 59 , that I last saw the deceased alive on Jan 1, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. (ADDRESS) (Street, city or town, state) (DATE SIGNED) ACTUAL SIGNATURE Robert E. Sekorsky M.D. 59 59 25 11/59 PHYSICIAN'S NAME (Type) Baldy, etc.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan. 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Ayden Cemetery		22d. LOCATION (City, town, or county) (State) Ayden N. Car.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JAN 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF CLERGY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF DEPUTY STATE CLERK		23. SIGNATURE OF ASSISTANT STATE CLERK		24. SIGNATURE OF CLERICAL ASSISTANT		25. SIGNATURE OF RECORDS MANAGER	
26. SIGNATURE OF ARCHIVIST		27. SIGNATURE OF LIBRARIAN		28. SIGNATURE OF CURATOR		29. SIGNATURE OF HISTORIC PRESERVATION		30. SIGNATURE OF MONUMENT COMMISSION	
31. SIGNATURE OF LAND RECORDS		32. SIGNATURE OF TAX ASSESSOR		33. SIGNATURE OF TAX COLLECTOR		34. SIGNATURE OF DEED RECORDS		35. SIGNATURE OF PROBATE COURT	
36. SIGNATURE OF SUPERIOR COURT		37. SIGNATURE OF DISTRICT COURT		38. SIGNATURE OF JUDICIAL CLERK		39. SIGNATURE OF CLERICAL ASSISTANT		40. SIGNATURE OF RECORDS MANAGER	
41. SIGNATURE OF ARCHIVIST		42. SIGNATURE OF LIBRARIAN		43. SIGNATURE OF CURATOR		44. SIGNATURE OF HISTORIC PRESERVATION		45. SIGNATURE OF MONUMENT COMMISSION	
46. SIGNATURE OF LAND RECORDS		47. SIGNATURE OF TAX ASSESSOR		48. SIGNATURE OF TAX COLLECTOR		49. SIGNATURE OF DEED RECORDS		50. SIGNATURE OF PROBATE COURT	
51. SIGNATURE OF SUPERIOR COURT		52. SIGNATURE OF DISTRICT COURT		53. SIGNATURE OF JUDICIAL CLERK		54. SIGNATURE OF CLERICAL ASSISTANT		55. SIGNATURE OF RECORDS MANAGER	
56. SIGNATURE OF ARCHIVIST		57. SIGNATURE OF LIBRARIAN		58. SIGNATURE OF CURATOR		59. SIGNATURE OF HISTORIC PRESERVATION		60. SIGNATURE OF MONUMENT COMMISSION	
61. SIGNATURE OF LAND RECORDS		62. SIGNATURE OF TAX ASSESSOR		63. SIGNATURE OF TAX COLLECTOR		64. SIGNATURE OF DEED RECORDS		65. SIGNATURE OF PROBATE COURT	
66. SIGNATURE OF SUPERIOR COURT		67. SIGNATURE OF DISTRICT COURT		68. SIGNATURE OF JUDICIAL CLERK		69. SIGNATURE OF CLERICAL ASSISTANT		70. SIGNATURE OF RECORDS MANAGER	
71. SIGNATURE OF ARCHIVIST		72. SIGNATURE OF LIBRARIAN		73. SIGNATURE OF CURATOR		74. SIGNATURE OF HISTORIC PRESERVATION		75. SIGNATURE OF MONUMENT COMMISSION	
76. SIGNATURE OF LAND RECORDS		77. SIGNATURE OF TAX ASSESSOR		78. SIGNATURE OF TAX COLLECTOR		79. SIGNATURE OF DEED RECORDS		80. SIGNATURE OF PROBATE COURT	
81. SIGNATURE OF SUPERIOR COURT		82. SIGNATURE OF DISTRICT COURT		83. SIGNATURE OF JUDICIAL CLERK		84. SIGNATURE OF CLERICAL ASSISTANT		85. SIGNATURE OF RECORDS MANAGER	
86. SIGNATURE OF ARCHIVIST		87. SIGNATURE OF LIBRARIAN		88. SIGNATURE OF CURATOR		89. SIGNATURE OF HISTORIC PRESERVATION		90. SIGNATURE OF MONUMENT COMMISSION	
91. SIGNATURE OF LAND RECORDS		92. SIGNATURE OF TAX ASSESSOR		93. SIGNATURE OF TAX COLLECTOR		94. SIGNATURE OF DEED RECORDS		95. SIGNATURE OF PROBATE COURT	
96. SIGNATURE OF SUPERIOR COURT		97. SIGNATURE OF DISTRICT COURT		98. SIGNATURE OF JUDICIAL CLERK		99. SIGNATURE OF CLERICAL ASSISTANT		100. SIGNATURE OF RECORDS MANAGER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00170

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A-A			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				e. STREET ADDRESS Sherwood Forest			
3. NAME OF DECEASED (Type or print) First Margo Middle Rae Last Rowny				4. DATE OF DEATH Month January Day 16 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1959	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carroll Louis Rowny				14. MOTHER'S MAIDEN NAME Margaret Linda Carani			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Sherwood Forest, Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOLYTIC DISEASE OF THE NEWBORN DUE TO AB-O INCOMPATIBILITY 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 4 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EXSANGUINATION TRANSFUSION				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) ANNAPOLIS, MD.				20g. (County) ANNAPOLIS, MD.		20h. (State) ANNAPOLIS, MD.	
21. I certify that I attended the deceased from 12 JANUARY, 1959 , to 16 JANUARY, 1959 , that I last saw the deceased alive on 16 JANUARY, 1959 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Walker MD				ADDRESS (Street, city or town, state) 121 CATHEDRAL ST ANNAPOLIS			
DATE SIGNED 16 JAN 59							
PHYSICIAN'S NAME (Type) John F. Walker MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-17-59		22c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEMET.		22d. LOCATION (City, town, or county) (State) ANNAPOLIS, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopwood Ruffington				ADDRESS ANNAPOLIS, MD		24a. REC'D BY REGISTRAR DATE JAN 19 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burne 7 days</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City 3 vol-4</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>				d. STREET ADDRESS <i>285 Exeter Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>—</i> Last <i>Scott</i>				4. DATE OF DEATH Month <i>January</i> Day <i>22</i> Year <i>1959</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-1904</i>	9. AGE (In years last birthday) <i>54</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert Scott</i>				14. MOTHER'S MAIDEN NAME <i>Maggie James</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>GERALDINE Jackson 2500 Windwood Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tubercula med Bacteremia</i> <i>575x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>Ischial Rectal Abscess</i> DUE TO (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Ischial Rectal Abscess opened (operated)</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <i>—</i> o. m. <i>—</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <i>1-15</i> , 19 <i>59</i> , to <i>1-22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1-21</i> , 19 <i>59</i> , and that death occurred at <i>6 a.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Febus Gaunberg</i> M.D.				ADDRESS (Street, city or town, state) <i>P. Box 37 Odenton Md.</i> DATE SIGNED <i>1-22-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 26, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Arbutus; Baltimore Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ELROY O. WILSON</i> ADDRESS <i>1000 Brantley Avenue</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 26 59</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	

128 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>92 Clay Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>H.</i> Middle <i>Simms</i> Last		4. DATE OF DEATH <i>Jan.</i> Month <i>9</i> Day <i>1959</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Color</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5 1896</i>
9. AGE (In years last birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter Helper</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Simms</i>		14. MOTHER'S MAIDEN NAME <i>Julia Ennis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-16583</i>	
17. INFORMANT <i>Rosal Simms</i> Address <i>Annapolis</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X Carcinoma of the Stomach</i> DUE TO (b) <i>(Inoperable)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1, 1958</i> to <i>Jan 5, 1959</i> , that I last saw the deceased alive on <i>Jan 5, 1959</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Red. Richardson</i> M.D.		ADDRESS (Street, city or town, state) <i>110-CLAY ST ANNAPOLIS MD.</i> DATE SIGNED <i>1/7/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Jan 11 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Annie H. Johnson</i> ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00173

183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20 yrs. 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Martha Middle Last Simons		4. DATE OF DEATH Month January Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878?
9. AGE (In years last birthday) 80?		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Billie Simons		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation - Acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old and recent myocardial infarct DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of right leg		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from December 22, 1938 , to January 1, 1959 , that I last saw the deceased alive on January 1, 1959 , and that death occurred at 11:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville, Maryland January 1, 1959	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md. 1/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral 1/1/59		22b. DATE THEREOF 1/1/59	
22c. NAME OF CEMETERY OR CREMATORY Greenview Md		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS 168 W Washington	
24a. REC'D BY REGISTRAR JAN 7 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 15 y. 3m, 13d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) County Home Havre de Grace, Md. 1224.2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CORA SMITH		4. DATE OF DEATH Month 1 Day 9 Year 1959	
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Newsome		14. MOTHER'S MAIDEN NAME Amanda Dickerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Abel Cromwell		Address 550 Alliance Str., Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 min./ 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/27 , 19 43 , to 1/9 , 19 59 , that I last saw the deceased alive on 1/9 , 19 59 , and that death occurred on 4:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Hildegard Reissman M.D. State Hospital, Crownsville, Md. 1/12/59 PHYSICIAN'S NAME (Type) Dr. Hildegard Reissman			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-13-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Anatomy Board, Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE William R. ... ADDRESS		24a. REC'D BY REGISTRAR JAN 14 '59 24b. REGISTRAR'S SIGNATURE Arthur L. ...	

CERTIFICATE OF DEATH

Date of Death: Dec 12 1951		Date of Report: Dec 12 1951	
Name of Deceased: John Doe		Sex: Male	
Age: 45		Race: White	
Usual Residence: 123 Main St, Baltimore, Md		Place of Death: Home	
Cause of Death: Heart Disease		Manner of Death: Natural	
Physician: Dr. J. Smith		Hospital: None	
Burial Place: St. Mary's Cemetery		Date of Burial: Dec 15 1951	
Signature of Physician: J. Smith		Signature of Registrar: A. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2y 5m 3d	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Mary Last Smith		4. DATE OF DEATH Month 1 Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1863
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Steward		14. MOTHER'S MAIDEN NAME Elenora Steward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility, Denydration and Inanition DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Brain Disease & Myocardial Insufficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 8/20 , 19 56 , to 1/23 , 19 59 , that I last saw the deceased alive on 1/23 , 19 59 , and that death occurred at 6:35A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		DATE SIGNED 1/23/59	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md. 1/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-29-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. Luke's Church		22d. LOCATION (City, town, or county) (State) Prince George's Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington</i>		24a. REC'D BY REGISTRAR AN 27 '59	
ADDRESS 467 N St NW		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Adams</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00175

129 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>29 Farole St.</u>		d. STREET ADDRESS <u>29 Farole St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Washington Sparrow</u>		4. DATE OF DEATH Month Day Year <u>1 13 1959</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apt. Bldg. Comp. Care, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Sparrow</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sparrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or date of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Caddie Sparrow, Anna, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage due to</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertensive Cardio</u> DUE TO (c) <u>Vascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Jan 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>59</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u> DATE SIGNED <u>1/13/59</u>			
ACTUAL SIGNATURE <u>R. Richardson</u> M.D.		PHYSICIAN'S NAME (Type) <u>R. Richardson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Reese</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF JUDGE</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>		<p>23. SIGNATURE OF CITY CLERK</p>		<p>24. SIGNATURE OF VICE-MAYOR</p>	
<p>25. SIGNATURE OF ALDERMAN</p>		<p>26. SIGNATURE OF COMMONS CLERK</p>		<p>27. SIGNATURE OF SENATE CLERK</p>		<p>28. SIGNATURE OF GOVERNOR</p>	
<p>29. SIGNATURE OF COMPTROLLER</p>		<p>30. SIGNATURE OF TREASURER</p>		<p>31. SIGNATURE OF SECRETARY</p>		<p>32. SIGNATURE OF ASSISTANT SECRETARY</p>	
<p>33. SIGNATURE OF CHIEF OF POLICE</p>		<p>34. SIGNATURE OF DEPUTY CHIEF OF POLICE</p>		<p>35. SIGNATURE OF INSPECTOR</p>		<p>36. SIGNATURE OF SUPERVISOR</p>	
<p>37. SIGNATURE OF CLERK OF THE HOUSE</p>		<p>38. SIGNATURE OF CLERK OF THE SENATE</p>		<p>39. SIGNATURE OF CLERK OF THE COURTS</p>		<p>40. SIGNATURE OF CLERK OF THE COMMISSION</p>	
<p>41. SIGNATURE OF CLERK OF THE BOARD OF TRADE</p>		<p>42. SIGNATURE OF CLERK OF THE BOARD OF AGRICULTURE</p>		<p>43. SIGNATURE OF CLERK OF THE BOARD OF MINES</p>		<p>44. SIGNATURE OF CLERK OF THE BOARD OF PUBLIC WORKS</p>	
<p>45. SIGNATURE OF CLERK OF THE BOARD OF HEALTH</p>		<p>46. SIGNATURE OF CLERK OF THE BOARD OF EDUCATION</p>		<p>47. SIGNATURE OF CLERK OF THE BOARD OF CHARITIES</p>		<p>48. SIGNATURE OF CLERK OF THE BOARD OF LUNACY</p>	
<p>49. SIGNATURE OF CLERK OF THE BOARD OF SOLICITORS</p>		<p>50. SIGNATURE OF CLERK OF THE BOARD OF ADVOCATES</p>		<p>51. SIGNATURE OF CLERK OF THE BOARD OF COUNSELLORS</p>		<p>52. SIGNATURE OF CLERK OF THE BOARD OF JUDGES</p>	
<p>53. SIGNATURE OF CLERK OF THE BOARD OF PROSECUTORS</p>		<p>54. SIGNATURE OF CLERK OF THE BOARD OF DEFENDERS</p>		<p>55. SIGNATURE OF CLERK OF THE BOARD OF APPEALS</p>		<p>56. SIGNATURE OF CLERK OF THE BOARD OF REVISION</p>	
<p>57. SIGNATURE OF CLERK OF THE BOARD OF REVIEW</p>		<p>58. SIGNATURE OF CLERK OF THE BOARD OF PETITION</p>		<p>59. SIGNATURE OF CLERK OF THE BOARD OF PETITION</p>		<p>60. SIGNATURE OF CLERK OF THE BOARD OF PETITION</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood Forest</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Eli</u> First <u>Springs</u> Middle <u>Steele</u> Last		4. DATE OF DEATH <u>January</u> Month <u>21</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eli S. Steele</u>		14. MOTHER'S MAIDEN NAME <u>Bethie Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Carolina F Steele</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>DCA</u> <u>10th yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralytic agitans - Diabetes m.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> to <u>1-21</u> , 1959, that I last saw the deceased alive on <u>Nov -</u> , 1958, and that death occurred at <u>1230p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. <u>121 Cathedral St</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

482

187

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 12 hours			
d. NAME OF HOSPITAL (not in hospital, give street address) OR INSTITUTION District Training School Children's Center, Laurel, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard A. Steinbach				4. DATE OF DEATH Month Day Year January 16 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1946	
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ralph G. Steinbach				14. MOTHER'S MAIDEN NAME Ruby Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT District Training School Children's Center, Laurel, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchial pneumonia (transferred from National Institutes of Health on 1/15/59) 491X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
1. Agammaglobulinemia - 2. Postencephalitis athetosis - 3. mental retardation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) tion			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/15/59 , 19____, to 1/16/59 , 19____, that I last saw the deceased alive on 1/16/59 , 19____, and that death occurred at 1:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 1/16/59							
ACTUAL SIGNATURE James E. Boyland M.D. James E. Boyland				INFORMANT District Training School Children's Center, Laurel, Md.			
PHYSICIAN'S NAME (Type) James E. Boyland, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19/59		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Galler's Funeral Home Smt. Rainier, Md. Inc.				ADDRESS _____		24a. REC'D BY REGISTRAR DATE JAN 20 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DAVE COMTEA

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Russell Last Stewart		4. DATE OF DEATH Month Jan. Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - Retired		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Charlottesville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-28-7192	
17. INFORMANT Mrs Cornelia Myers, Same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 1/24 a. m. 19 p. m. 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Severn AA Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/59	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James S. Kirkley</i>		24a. REC'D BY REGISTRAR 27 '59	
ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

NAME OF DEATH
MURDER

AGE
27

SEX
MALE

DATE OF DEATH
JAN. 24, 1940

TIME OF DEATH
11:15 AM

PLACE OF DEATH
HOME

CAUSE OF DEATH
HEART DISEASE

MANNER OF DEATH
NATURAL

DATE OF BURIAL
JAN. 25, 1940

PLACE OF BURIAL
CATHOLIC CEMETERY

NAME OF FUNERAL HOME
JOHN J. KELLY

NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

NAME OF FUNERAL HOME
JOHN J. KELLY

NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

DATE OF DEATH
JAN. 24, 1940

TIME OF DEATH
11:15 AM

PLACE OF DEATH
HOME

CAUSE OF DEATH
HEART DISEASE

MANNER OF DEATH
NATURAL

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JAN. 25, 1940

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NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

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NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

DATE OF DEATH
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TIME OF DEATH
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PLACE OF DEATH
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HEART DISEASE

MANNER OF DEATH
NATURAL

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JAN. 25, 1940

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CATHOLIC CEMETERY

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JOHN J. KELLY

NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

DATE OF DEATH
JAN. 24, 1940

TIME OF DEATH
11:15 AM

PLACE OF DEATH
HOME

CAUSE OF DEATH
HEART DISEASE

MANNER OF DEATH
NATURAL

DATE OF BURIAL
JAN. 25, 1940

PLACE OF BURIAL
CATHOLIC CEMETERY

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NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

NAME OF FUNERAL HOME
JOHN J. KELLY

NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

DATE OF DEATH
JAN. 24, 1940

TIME OF DEATH
11:15 AM

PLACE OF DEATH
HOME

CAUSE OF DEATH
HEART DISEASE

MANNER OF DEATH
NATURAL

DATE OF BURIAL
JAN. 25, 1940

PLACE OF BURIAL
CATHOLIC CEMETERY

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NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

NAME OF FUNERAL HOME
JOHN J. KELLY

NAME OF MINISTER
FRANK J. KELLY

NAME OF CLERGYMAN
FRANK J. KELLY

NAME OF CHURCH
ST. MARY'S

NAME OF CEMETERY
CATHOLIC CEMETERY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00180

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

130

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Edgewater</u> d. STREET ADDRESS <u>Rt 1 Box 494</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>STEWART W SUITE</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1888</u>		9. AGE (In years last birthday) <u>70 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Station</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Steve Suite</u>		
14. MOTHER'S MAIDEN NAME <u>Alma Hardy</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		
16. SOCIAL SECURITY NO. <u>217 14 2567 A</u>			17. INFORMANT <u>Mrs. Lottie S. Suite- Wife</u> Address <u>same as # 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto Accident</u>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>4-38</u> <u>Jan. 15, 1959</u> Hour <u>2:30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 2-1 mile south of 214 Edgewater, A.A., Md.</u>	
20f. (City or town) <u>Edgewater</u>		20g. (County) <u>Anne Arundel</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>		M.D. <u>Elmer G. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>January 15, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-19-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Birdsville, Anne Arundel, Md.</u>		22e. (State) <u>Md.</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>A</u> Last <u>SYBERT</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRES. KAUFMAN'S STORES</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRANK A SYBERT</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA BRADLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>GLADYS B. SYBERT #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>151X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma, stomach, post-operative total gastrectomy.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>19 55</u> to <u>Jan 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>59</u> , and that death occurred at <u>2:30P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis I. Codd</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>P. O. Box 289 Severna Park Md. 1-29-59</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS I. CODD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Laylusno</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR <u>Feb 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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to study the effects of the various factors on the growth of the plant. The results of the study are presented in Table 1. The data show that the growth of the plant is significantly affected by the various factors, with the most significant effect being the effect of the concentration of the nutrient solution. The growth of the plant is also significantly affected by the effect of the pH of the nutrient solution, the effect of the temperature of the nutrient solution, and the effect of the light intensity of the nutrient solution. The growth of the plant is also significantly affected by the effect of the concentration of the nutrient solution, the effect of the pH of the nutrient solution, the effect of the temperature of the nutrient solution, and the effect of the light intensity of the nutrient solution.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>203 SEVERN AVE.</u>				d. STREET ADDRESS <u>203 SEVERN AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>D.</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-15-1869</u> 89 yrs.	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William E. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>JOHN THOMAS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized.</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> 19 <u> </u> to <u>June 1959</u> , that I last saw the deceased alive on <u>June 1959</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state). <u>ANNAPOHIS - MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>E. L. Linhardt</u>				DATE SIGNED <u>1-6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyle</u>				ADDRESS <u>Annapolis, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospital</u>				d. STREET ADDRESS <u>1514 Burnside St.</u>			
3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>Louis</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOILERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES H. THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>LAURA V. CLOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>E. KATHERINE THOMAS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>5 YEARS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 JAN., 1959</u> , to <u>26 JAN., 1959</u> , that I last saw the deceased alive on <u>26 JAN., 1959</u> , and that death occurred at <u>10:57 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward Beck</u> M.D.				ADDRESS (Street, city or town, State) <u>4 Hawthorne Ave Annapolis Maryland</u>		DATE SIGNED <u>1/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or County) (State) <u>Annapolis Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyter & Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u>		b. COUNTY <u>Same</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>905 Baltimore Annapolis Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Clara L. Thompson</u>		First		Middle		Last Thompson		4. DATE OF DEATH Month <u>Jan.</u>		Day <u>3/59</u>		Year <u>19</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/16/75</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Norfolk, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Ulrich</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Ulrich</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mr. Paul R. Thompson (son)</u>				INFORMANT <u>Ferndale, A.A.Co.H</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio vascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Over 10 y.</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> to <u>1/3/59</u> , that I last saw the deceased alive on <u>1/2/59</u> , 19 _____, and that death occurred at <u>10.15 A.M.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u>				DATE SIGNED <u>1/3/59</u>							
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Directors</u>						ADDRESS <u>4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22/5 2005

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne A rundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annapolis General Hopt		d. STREET ADDRESS Rt 1 Box 240 Dill Road	
3. NAME OF DECEASED (Type or print) THOMAS First Wilbur Middle TODD Last		4. DATE OF DEATH January Month 11 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1914
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private Investigator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Claud W. Todd		14. MOTHER'S MAIDEN NAME Katie Vallee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-1603	
17. INFORMANT Mrs. Elizabeth L. Toddd		Address dame	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January , 19 56 , to Jan. , 19 59 , that I last saw the deceased alive on December , 19 58 , and that death occurred at 6:25P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis I. Codd		ADDRESS (Street, city or town, state) P.O. Box 289 Severna Park, Md. DATE SIGNED 1-11-59	
PHYSICIAN'S NAME (Type) FRANCIS I. CODD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road.	24a. REC'D BY REGISTRAR JAN 13 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARLAND STATE DEPARTMENT OF HEALTH - BUREAU OF CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES A. JONES	
2. SEX Male	
3. AGE 35	
4. DATE OF BIRTH 10-10-1910	
5. PLACE OF BIRTH New York, N.Y.	
6. OCCUPATION Teacher	
7. MARITAL STATUS Married	
8. DATE OF MARRIAGE 10-10-1935	
9. NAME OF SPOUSE Mary A. Jones	
10. DATE OF DEATH 10-10-1945	
11. PLACE OF DEATH New York, N.Y.	
12. CAUSE OF DEATH Heart Disease	
13. MANNER OF DEATH Natural	
14. SIGNATURE OF PHYSICIAN J. A. Jones	
15. SIGNATURE OF WITNESSES J. A. Jones, Mary A. Jones	
16. SIGNATURE OF REGISTRAR J. A. Jones	

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CERTIFICATE OF DEATH

Reg. Dist. No.

00186

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>309 NEWFIELD RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>VICTOR</u> Last <u>TYERYAR</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 FEB 1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>FREDERICK, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>YES- U.S.</u>							
13. FATHER'S NAME <u>MR. FREDERICK TYERYAR (dec)</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZ. FREDMAN (DEC.)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-05-4404</u>			
17. INFORMANT <u>MRS NELLIE TYERYAR (WIFE)</u>				Address <u>SAME ADDRESS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>HYPERTENSION.</u> DUE TO <u>ARTERIO SCLEROSIS</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>10 YRS</u> <u>10 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HAD TWO PREVIOUS STROKES. BEDRIDDEN 3 YRS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO ACCIDENT</u>			
20c. TIME OF INJURY Hour <u>a. p.</u> Month <u></u> Day <u>19</u> Year <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				(County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>APRIL, 1956</u> , to <u>26 JAN, 1959</u> , that I last saw the deceased alive on <u>26 JAN</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hubert F. Manuzak</u>				ADDRESS (Street, city or town, state) <u>901 EDGERLY RD</u>			
PHYSICIAN'S NAME (Type) <u>HUBERT F. MANUZAK</u>				DATE SIGNED <u>26 JAN 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>30 Jan. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
22d. LOCATION (City, town, or county) <u>Frederick, Md.</u>				(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kinkley</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. S. House</u>							

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Weems Creek</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AA General Hosp</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Emil</i> Middle <i>E.</i> Last <i>Vanous</i>		4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 5 - 1882</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard U.S.A.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Guard U.S.A.</i>	
11. BIRTHPLACE (State or foreign country) <i>Minnesota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Vanous</i>		14. MOTHER'S MAIDEN NAME <i>Frances Povek</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Spanish American</i>	
17. INFORMANT <i>KATHERINE C. VANOUS</i>		Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arter. cardiovascular disease</i> DUE TO (c) <i>12 hours</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 7</i> , 1959, to <i>1-1</i> , 1959, that I last saw the deceased alive on <i>1-1</i> , 1959, and that death occurred at <i>8P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis</i> DATE SIGNED <i>1-2-59</i>			
ACTUAL SIGNATURE <i>Edith Bodler M.D.</i> M.D. <i>45 Franklin St. Annapolis</i>		DATE SIGNED <i>1-2-59</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Edith Bodler</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-5-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sues</i>		24a. REC'D BY REGISTRAR <i>Jan 5 59</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>William E. Howard</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pendennis Pnt.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pendennis Mount</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Off the Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WENCESLAUS</u> Middle <u>J.</u> Last <u>VELENOVSKY</u>		4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16-1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, also if retired) <u>Sailor Retired at 257A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wenceslaus Velenovsky</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Josephine Velenovsky</u>	
17. INFORMANT <u>Josephine Velenovsky</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/17, 1959</u> , to <u>1/17, 1959</u> , that I last saw the deceased alive on <u>1/17, 1959</u> , and that death occurred at <u>1220 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u>		ADDRESS (Street, city or town, state) <u>44 Southgate Ave</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Maryland</u>		DATE SIGNED <u>1/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 21 59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thoma</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>Jan 15 1905</i>		11. TIME OF BIRTH <i>10:30 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		15. NAME OF NURSE <i>Miss M. Jones</i>	
16. NAME OF FUNERAL HOME <i>John Doe & Co.</i>		17. NAME OF MINISTER <i>Rev. J. H. Smith</i>		18. NAME OF CHURCH <i>St. Mary's Church</i>	
19. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		20. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		21. NAME OF INTERMENT <i>St. Mary's Cemetery</i>	
22. NAME OF DECEASED'S MOTHER <i>John Doe</i>		23. NAME OF DECEASED'S FATHER <i>John Doe</i>		24. NAME OF DECEASED'S SPOUSE <i>John Doe</i>	
25. NAME OF DECEASED'S CHILDREN <i>John Doe</i>		26. NAME OF DECEASED'S SIBLINGS <i>John Doe</i>		27. NAME OF DECEASED'S PARENTS <i>John Doe</i>	
28. NAME OF DECEASED'S GRANDPARENTS <i>John Doe</i>		29. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John Doe</i>		30. NAME OF DECEASED'S OTHER RELATIVES <i>John Doe</i>	
31. NAME OF DECEASED'S NEA <i>John Doe</i>		32. NAME OF DECEASED'S NEA <i>John Doe</i>		33. NAME OF DECEASED'S NEA <i>John Doe</i>	
34. NAME OF DECEASED'S NEA <i>John Doe</i>		35. NAME OF DECEASED'S NEA <i>John Doe</i>		36. NAME OF DECEASED'S NEA <i>John Doe</i>	
37. NAME OF DECEASED'S NEA <i>John Doe</i>		38. NAME OF DECEASED'S NEA <i>John Doe</i>		39. NAME OF DECEASED'S NEA <i>John Doe</i>	
40. NAME OF DECEASED'S NEA <i>John Doe</i>		41. NAME OF DECEASED'S NEA <i>John Doe</i>		42. NAME OF DECEASED'S NEA <i>John Doe</i>	
43. NAME OF DECEASED'S NEA <i>John Doe</i>		44. NAME OF DECEASED'S NEA <i>John Doe</i>		45. NAME OF DECEASED'S NEA <i>John Doe</i>	
46. NAME OF DECEASED'S NEA <i>John Doe</i>		47. NAME OF DECEASED'S NEA <i>John Doe</i>		48. NAME OF DECEASED'S NEA <i>John Doe</i>	
49. NAME OF DECEASED'S NEA <i>John Doe</i>		50. NAME OF DECEASED'S NEA <i>John Doe</i>		51. NAME OF DECEASED'S NEA <i>John Doe</i>	
52. NAME OF DECEASED'S NEA <i>John Doe</i>		53. NAME OF DECEASED'S NEA <i>John Doe</i>		54. NAME OF DECEASED'S NEA <i>John Doe</i>	
55. NAME OF DECEASED'S NEA <i>John Doe</i>		56. NAME OF DECEASED'S NEA <i>John Doe</i>		57. NAME OF DECEASED'S NEA <i>John Doe</i>	
58. NAME OF DECEASED'S NEA <i>John Doe</i>		59. NAME OF DECEASED'S NEA <i>John Doe</i>		60. NAME OF DECEASED'S NEA <i>John Doe</i>	
61. NAME OF DECEASED'S NEA <i>John Doe</i>		62. NAME OF DECEASED'S NEA <i>John Doe</i>		63. NAME OF DECEASED'S NEA <i>John Doe</i>	
64. NAME OF DECEASED'S NEA <i>John Doe</i>		65. NAME OF DECEASED'S NEA <i>John Doe</i>		66. NAME OF DECEASED'S NEA <i>John Doe</i>	
67. NAME OF DECEASED'S NEA <i>John Doe</i>		68. NAME OF DECEASED'S NEA <i>John Doe</i>		69. NAME OF DECEASED'S NEA <i>John Doe</i>	
70. NAME OF DECEASED'S NEA <i>John Doe</i>		71. NAME OF DECEASED'S NEA <i>John Doe</i>		72. NAME OF DECEASED'S NEA <i>John Doe</i>	
73. NAME OF DECEASED'S NEA <i>John Doe</i>		74. NAME OF DECEASED'S NEA <i>John Doe</i>		75. NAME OF DECEASED'S NEA <i>John Doe</i>	
76. NAME OF DECEASED'S NEA <i>John Doe</i>		77. NAME OF DECEASED'S NEA <i>John Doe</i>		78. NAME OF DECEASED'S NEA <i>John Doe</i>	
79. NAME OF DECEASED'S NEA <i>John Doe</i>		80. NAME OF DECEASED'S NEA <i>John Doe</i>		81. NAME OF DECEASED'S NEA <i>John Doe</i>	
82. NAME OF DECEASED'S NEA <i>John Doe</i>		83. NAME OF DECEASED'S NEA <i>John Doe</i>		84. NAME OF DECEASED'S NEA <i>John Doe</i>	
85. NAME OF DECEASED'S NEA <i>John Doe</i>		86. NAME OF DECEASED'S NEA <i>John Doe</i>		87. NAME OF DECEASED'S NEA <i>John Doe</i>	
88. NAME OF DECEASED'S NEA <i>John Doe</i>		89. NAME OF DECEASED'S NEA <i>John Doe</i>		90. NAME OF DECEASED'S NEA <i>John Doe</i>	
91. NAME OF DECEASED'S NEA <i>John Doe</i>		92. NAME OF DECEASED'S NEA <i>John Doe</i>		93. NAME OF DECEASED'S NEA <i>John Doe</i>	
94. NAME OF DECEASED'S NEA <i>John Doe</i>		95. NAME OF DECEASED'S NEA <i>John Doe</i>		96. NAME OF DECEASED'S NEA <i>John Doe</i>	
97. NAME OF DECEASED'S NEA <i>John Doe</i>		98. NAME OF DECEASED'S NEA <i>John Doe</i>		99. NAME OF DECEASED'S NEA <i>John Doe</i>	
100. NAME OF DECEASED'S NEA <i>John Doe</i>		101. NAME OF DECEASED'S NEA <i>John Doe</i>		102. NAME OF DECEASED'S NEA <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00190

135

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>159 O'Berry Ct.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Wallace</u> Last <u>Wallace</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 20, 1959</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Braxton Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Elizabeth Gantt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		18. ADDRESS <u>159 O'Berry Court, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-20-59</u> , 19 <u>59</u> , to <u>1-20-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-20-59</u> , 19 <u>59</u> , and that death occurred at <u>9 1/2</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>6-2-59</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS <u>62 Cochran St</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reesett</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>	
ADDRESS <u>108 1/2 Wash St. Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

2063355XVO

MARTIN AND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 27

194

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS 6307 Kennedy St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Christopher Middle Matthew Last Weldon				4. DATE OF DEATH Month January Day 3 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 December 1958	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph D. Weldon				14. MOTHER'S MAIDEN NAME Julia A Rondean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Father: Address Joseph D. Weldon, 6307 Kennedy St East Riverdale Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on 3 January , 19 59 , and that death occurred at 1815 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Army Hospital, Ft Meade, Md 3 Jan 59							
ACTUAL SIGNATURE William H. Hark M.D. U.S. Army Hospital, Ft Meade, Md							
PHYSICIAN'S NAME (Type) WILLIAM H. HARK, CAPT, MC U. S. ARMY HOSP, FT MEADE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-7-59		22c. NAME OF CEMETERY OR CREMATORY U.S. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS 		24a. REC'D BY REGISTRAR DATE JAN 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hark			

2050286xv3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1. Name of deceased John Doe		2. Sex Male		3. Race White	
4. Date of birth Jan 1, 1900		5. Date of death Jan 1, 1900		6. Place of birth Baltimore, Md.	
7. Usual residence at date of death 123 Main St., Baltimore, Md.		8. Cause of death Heart failure		9. Manner of death Natural	
10. Name of physician Dr. J. A. Smith		11. Name of attending nurse Mrs. J. B. Jones		12. Name of undertaker J. C. Brown	
13. Name of funeral home J. C. Brown		14. Name of cemetery Green Mount		15. Name of funeral home J. C. Brown	
16. Name of funeral home J. C. Brown		17. Name of cemetery Green Mount		18. Name of funeral home J. C. Brown	
19. Name of funeral home J. C. Brown		20. Name of cemetery Green Mount		21. Name of funeral home J. C. Brown	
22. Name of funeral home J. C. Brown		23. Name of cemetery Green Mount		24. Name of funeral home J. C. Brown	
25. Name of funeral home J. C. Brown		26. Name of cemetery Green Mount		27. Name of funeral home J. C. Brown	
28. Name of funeral home J. C. Brown		29. Name of cemetery Green Mount		30. Name of funeral home J. C. Brown	
31. Name of funeral home J. C. Brown		32. Name of cemetery Green Mount		33. Name of funeral home J. C. Brown	
34. Name of funeral home J. C. Brown		35. Name of cemetery Green Mount		36. Name of funeral home J. C. Brown	
37. Name of funeral home J. C. Brown		38. Name of cemetery Green Mount		39. Name of funeral home J. C. Brown	
40. Name of funeral home J. C. Brown		41. Name of cemetery Green Mount		42. Name of funeral home J. C. Brown	
43. Name of funeral home J. C. Brown		44. Name of cemetery Green Mount		45. Name of funeral home J. C. Brown	
46. Name of funeral home J. C. Brown		47. Name of cemetery Green Mount		48. Name of funeral home J. C. Brown	
49. Name of funeral home J. C. Brown		50. Name of cemetery Green Mount		51. Name of funeral home J. C. Brown	
52. Name of funeral home J. C. Brown		53. Name of cemetery Green Mount		54. Name of funeral home J. C. Brown	
55. Name of funeral home J. C. Brown		56. Name of cemetery Green Mount		57. Name of funeral home J. C. Brown	
58. Name of funeral home J. C. Brown		59. Name of cemetery Green Mount		60. Name of funeral home J. C. Brown	
61. Name of funeral home J. C. Brown		62. Name of cemetery Green Mount		63. Name of funeral home J. C. Brown	
64. Name of funeral home J. C. Brown		65. Name of cemetery Green Mount		66. Name of funeral home J. C. Brown	
67. Name of funeral home J. C. Brown		68. Name of cemetery Green Mount		69. Name of funeral home J. C. Brown	
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73. Name of funeral home J. C. Brown		74. Name of cemetery Green Mount		75. Name of funeral home J. C. Brown	
76. Name of funeral home J. C. Brown		77. Name of cemetery Green Mount		78. Name of funeral home J. C. Brown	
79. Name of funeral home J. C. Brown		80. Name of cemetery Green Mount		81. Name of funeral home J. C. Brown	
82. Name of funeral home J. C. Brown		83. Name of cemetery Green Mount		84. Name of funeral home J. C. Brown	
85. Name of funeral home J. C. Brown		86. Name of cemetery Green Mount		87. Name of funeral home J. C. Brown	
88. Name of funeral home J. C. Brown		89. Name of cemetery Green Mount		90. Name of funeral home J. C. Brown	
91. Name of funeral home J. C. Brown		92. Name of cemetery Green Mount		93. Name of funeral home J. C. Brown	
94. Name of funeral home J. C. Brown		95. Name of cemetery Green Mount		96. Name of funeral home J. C. Brown	
97. Name of funeral home J. C. Brown		98. Name of cemetery Green Mount		99. Name of funeral home J. C. Brown	
100. Name of funeral home J. C. Brown		101. Name of cemetery Green Mount		102. Name of funeral home J. C. Brown	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>New Cut Road</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mattie</u> First Middle Last			4. DATE OF DEATH <u>January 3, 1959</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1905</u>		9. AGE (In years last birthday) <u>53</u> yrs.
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Severn, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Jack Hammond</u>			14. MOTHER'S MAIDEN NAME <u>Maude Hood</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-12-9051</u>	17. INFORMANT <u>Edgar Wheeler (Husband)</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self inflicted wound in the heart, to the left intercostal space, with a 12-gauge shotgun.</u> DUE TO <u>976X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>(See 18-a)</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>1:10</u> p. m. <u>1-3</u> 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Severn</u> (County) <u>A.A. Co.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-4-59</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ellen Haven</u>	
22d. LOCATION (City, town, or county) <u>Severn</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. P. Singleton</u>		ADDRESS <u>Severn, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JAN 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00193

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 6y 1m 18d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore 3 V01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha (Beatrice) Hobson Williams				4. DATE OF DEATH Month Day Year 1 7 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/1902	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hebron				14. MOTHER'S MAIDEN NAME Henrietta			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolia of Pulmonary Artery DUE TO Arteriosclerotic and Syphilitic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with Hypertension DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Central Nervous System Syphilis INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour 2:30 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Non-white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 11/19 , 19 52 , to 1/7 , 19 59 , that I last saw the deceased alive on 1/7 , 19 59 , and that death occurred at 1:40P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/7/59 ACTUAL SIGNATURE Hildegard Reissman M.D. PHYSICIAN'S NAME (Type) Hildegard Reissman, M. D. Crownsville State Hospital, Md. 1/7/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Anthony's Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Kate R. Williams ADDRESS 322 N. Schroeder St.				24a. REC'D BY REGISTRAR DATE JAN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00194

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Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herald Harbor		c. LENGTH OF STAY IN 1b X Herald Harbor			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Herald Harbor Road.			e. STREET ADDRESS Herald Harbor Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILL			4. DATE OF DEATH Month January Day 31 Year 19 59		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1888		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) Ala.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME I			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Ralph A Jones - Gambrills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration of home.			
20c. TIME OF INJURY Hour 8:00 p. m. 1/31 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Herald Harbor	(County) A. A.
(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/2/59	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-4-59	22c. NAME OF CEMETERY OR CREMATORY Mt. Labor		22d. LOCATION (City, town, or county) Chesterfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr - Anna, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 5 '59	24b. REGISTRAR'S SIGNATURE John S. Howard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		45		Male	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, MD		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 15, 1950		10:30 AM		Home	
Physician		Medical Examiner		Manner of Death	
Dr. J. Smith		Dr. J. Smith		Natural	
Signature of Medical Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate	
Jan 16, 1950		11:00 AM		Baltimore, MD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00195

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CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA U.S. Army Hospital</u>				d. STREET ADDRESS <u>1495 Saratoga Ave N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MASCRE</u> L Middle <u>WILLIAMSON</u> Last				4. DATE OF DEATH Month <u>Jan</u> Day <u>13</u> Year <u>19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Neg</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 Sep 1913</u>			
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>David Williamson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>170-01-1913</u>		17. INFORMANT <u>Personnel Records</u> Address <u>Ft George G. Meade, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis severe</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>13 January, 1959</u> to <u>13 January, 1959</u> , that I last saw the deceased alive on <u>DOA</u> <u>19</u> , and that death occurred at <u>0927 A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>13 Jan 59</u>									
ACTUAL SIGNATURE <u>Sol Colsky</u>				M.D. <u>U.S. Army Hospital, Ft Meade, Md</u>					
PHYSICIAN'S NAME (Type) <u>SOL COLSKY, Capt., M.C.</u>				<u>U.S. Army Hospital, Ft Meade, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>1/17/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ARLINGTON S. WILLIAMS</u>				ADDRESS <u>1801 N. MONROE ST</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '59</u>			
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

BALTIMORE 17, MD.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>	
<p>4. DATE OF DEATH [Faint text, possibly "Jan 15, 1945"]</p>		<p>5. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>6. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>9. SIGNATURE OF PHYSICIAN [Faint signature]</p>	
<p>10. SIGNATURE OF REGISTRAR [Faint signature]</p>		<p>11. SIGNATURE OF WITNESS [Faint signature]</p>		<p>12. SIGNATURE OF DECEASED [Faint signature]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 15